School District: _____ School: _____ Grade: _____

School Medication Administration Authorization Form

Name of Student: _____ **Date of Birth**: _____

Medication (1):_____ Dose: _____

Diagnosis: _____

Frequency of Medication: _____ If PRN, frequency: _____

Side effects: ○ None expected ○ Specify: _____

Self-Administration: ○ YES ○ NO Self-Carry: ○ YES ○ NO

Medication (2):_____ Dose: _____

Diagnosis: _____

Frequency of Medication: _____ If PRN, frequency: _____

Side effects: ○ None expected ○ Specify: _____

Self-Administration: ○ YES ○ NO Self-Carry: ○ YES ○ NO

Medication (3):_____ Dose: _____

Diagnosis: _____

Frequency of Medication: _____ If PRN, frequency: _____

Side effects: ○ None expected ○ Specify: _____

Self-Administration: ○ YES ○ NO Self-Carry: ○ YES ○ NO

Prescriber's Name/Title: Barbara Deuell, MD Robert Hickey, MD Kevin Roelofs, MD Amitha Harish, MD

Address: 100 Griffin Road Suite A Portsmouth, NH 03801

Telephone: 603-436-7897 Fax: 603-436-7855

Prescriber's Signature: _____ Date: _____

I understand and agree that if the school nurse has questions regarding the physician/primary health care provider's order, that the nurse may contact the child's physician and obtain additional information from him or her about the medication, and I consent the physician providing that information.

Signature of Parent/Guardian: _____ Date: _____

Relationship: _____ Phone Number: _____