HOOKSETT SCHOOL DISTRICT
MEDICATION ADMINISTRATION FORM

PARENT/GUARDIAN, PLEASE FILL OUT:

Name of student _____ DOB _____
Teacher _____Grade _____
Name of Medication _____
Dose to be given _____ Rx # _____
Time & frequency of med. to be given _____
Reason med. is given _____
Doctor prescribing _____
Beginning (list dates) : _____ to _____

The medication **MUST** be delivered to the School Nurse or Principal's office by a parent or responsible adult. **All medication is to be in the original container properly labeled student's name, MD name, name and dosage of medication.**

_____ _____
Parent/Guardian Signature Date

PHYSICIAN, PLEASE FILL OUT:
Students Name _____ Diagnosis _____
Medication/Dosage _____ Time schedule _____
Medication to be taken from _____to_____
Licensed Provider Signature: _____ Date _____
Printed Name: _____

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FOR METERED DOSE INHALERS OR EPIPEN MEDICATION ONLY:
IF YOU REQUEST THAT YOUR CHILD CARRY HIS/HER INHALER OR EPIPEN WITH THEM, PLEASE HAVE THE FOLOLLOWING FILLED OUT:

MD:
I have instructed _____ in the proper way to use _____.
It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself without supervision. **YES** **NO**

LicensedProviderSignature: _____ Date _____

PARENT:
I agree with the above physician's statement that my child has been instructed in the proper way to use this medication and should be allowed to carry and use that medication by him/herself without supervision.
I give my child permission to do so. **YES** **NO**

IMMEDIATELY AFTER USING THE EPIPEN OR INHALER DURING THE SCHOOL DAY, THE STUDENT MUST REPORT TO THE NURSE OR MAIN OFFICE FOR APPROPRIATE FOLLOW-UP CARE.

Parent/Guardian Signature: _____ Date _____