PITTSFIELD MIDDLE HIGH SCHOOL
23 Oneida Street
Pittsfield, New Hampshire 03263
Phone: (603) 435-6701 • Fax (603) 435-7087

Administration of Medication in School

The *New Hampshire State Department of Education* policy concerning the administration of medications in school requires that the following steps be completed ***BEFORE*** medication can be given during school hours:

1. A written order from a licensed provider that includes the student's name, date, diagnosis, the name of the medication, the dosage, the route, the time the medication is to be administered and the length of time the student will be taking the medication.
2. "Authorization for Prescribed Medication during the School Day" must be signed by parent or guardian.
3. The medication needs to be brought in by the parent or guardian in the original prescription container. No more than one month supply at a time. Unused medication must be picked up within ten days or it will be disposed of by the school nurse and recorded as such.

Authorization for Prescribed Medication during the School Day

I, the parent/guardian, request that my child _____ (*student's name*) be administered, or assisted in, taking his/her prescribed medication during school hours. I agree, by signing this statement, that I will not hold liable the school district, school nurse or any member of the school district staff who are directed by the nurse to assist my child in taking his/her medication.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Printed Name: _____

Permission to Exchange Information

I hereby give permission to _____ (*prescribing provider*) to release/discuss health information to the Pittsfield School District Nurse concerning _____ (*student's name*).
I understand that I may revoke this authorization at any time by submitting a written revocation to the Pittsfield School District. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Printed Name: _____

(Over for Side Two)

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Medication Order
(*To be completed by licensed provider*)

Date: _____

I hereby instruct the designated member of the school district staff to assist _____ (*student's name*) in taking their medication for a diagnosis of _____.

Name of Medication: _____ Start Date: _____ End Date: _____
Directions/Time to be administered/Route: _____

***If applicable:** This student ☐ (may) ☐ (may not) carry his/her own ☐ (inhaler) ☐ (Epi Pen) and use as directed.

Provider Signature: _____ Date: _____
Provider Name Printed: _____ Phone Number: _____

- ☐ **Allergy Action Plan** Completed by Provider and signed by parent/guardian. (Required for Epi Pen)
- ☐ **Asthma Action Plan** Completed by Provider and signed by parent/guardian. (Required for Asthma)

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date Received: _____