Health Services Department
5 Pinkerton Street, Derry, NH 03038
Phone: 603-437-5218 Fax: 603-437-5219

Linda Brennick, RN Head Nurse
Mrs. D. M. Clark, BSN, RN, NCSN School Nurse
Ms. J. Nadeau, BSN, RN School Nurse
Mrs. L. S. Roy, RN School Nurse
Mrs. L. L. Sica, RN School Nurse

**PERMISSION FORM FOR MEDICATION**

Dear Parent/Guardian and Physician:

The school is required to keep on file a letter from the student's physician/prescriber authorizing a student to take a medication during school hours. This must specify the name, dosage, time to be taken, expected duration of order, and side effects. If the medication is changed, a new order must be written. Without this, your son/daughter **cannot** receive the medication during school hours. Please complete and return this form to enable us to make the necessary arrangements for medication during school hours. Thank you for your assistance and cooperation.

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**PHYSICIAN/PRESCRIBER SECTION**

_____ has been prescribed the following medication:

_____ for _____
(name of medication, dosage, etc.) (expected duration of order)

Additional information pertaining to this patient, medication, etc. **(If the medication must be carried on the student's person ex. inhaler, Epipen, etc. this must be specified.):**

_____

_____

Date: _____ Prescriber Signature: _____

Prescriber Name (please print): _____

Address: _____ Telephone #: _____

Has the student/patient been trained on how to use an epi-pen and/or inhaler? _____

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PARENT/GUARDIAN SECTION

I, the parent/guardian, authorize the school nursing staff to assist and record the proper administration of this medication or treatment and to contact the physician as needed. We agree that we will not hold liable any member of the school staff whose duty it is to assist our child in taking the medication or treatment.

Date:_____ Signature of parent:_____ Telephone #: _____

**Note: Medication must be in the original pharmacy labeled container. Only a 30 day supply can be accepted at any time. ALL CONTROLLED SUBSTANCES (ex. Ritalin, Adderal, Dexedrine, etc.) MUST BE DELIVERED TO THE HEALTH OFFICE BY A PARENT OR GUARDIAN.**