GOVERNOR WENTWORTH REGIONAL SCHOOL DISTRICT
MEDICATION PERMISSION FORM

PHYSICIAN'S STATEMENT

Because of state regulations the school must have the following information to administer medications during the school day.

STUDENT'S NAME: _____ GRADE: _____
DIAGNOSIS:_____
NAME OF MEDICATION: _____ROUTE: _____
DOSE TO BE GIVEN: _____TIME: _____
START DATE: _____ STOP DATE: _____
SIDE EFFECTS/OBSERVATIONS: _____

_____ _____
DATE PHYSICIAN'S SIGNATURE

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SELF CARRY POLICY

The policy in the Governor Wentworth Regional School District is that students do not carry medications on their person in school. However, there are situations (i.e. inhalers and Epi-Pens) that may create exceptions to this policy. If you feel this student can safely self carry and administer the medication indicated, please, fill out the information below.
Please allow the student named above to carry and self-administer _____
NAME OF MEDICATION
due to of the diagnosis of _____.

_____ _____
DATE PHYSICIAN'S SIGNATURE

PARENTAL PERMISSION

MEDICATION POLICY

- The medication must be delivered to the school by an adult and will be kept in a locked medication cabinet in the health office.
- The medication needs to be in a properly labeled container from the pharmacy with the date of the prescription, the student's name, the name of the medication and the physician's name.
- A written statement or the above portion of this form signed by the physician is necessary for your child to receive medication at school.
- The parent must sign the form below to give permission for the medication.

We the parent(s) authorize the school to assist our child in taking the above medication and agree that we will not hold liable any member of the school staff who has been directed by us(the parents) and the School Administrator.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

I authorize my child's physician to release any information necessary regarding this illness to the school nurse.

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

Revised: 9/15/09