



Concord Christian Academy
37 Regional Drive, Concord, NH 03301
228-8888 Fax 226-9696

ADMINISTRATION OF PRESCRIPTION MEDICATIONS

Parent Permission Form

According to the NH Code of Administrative Rules: Education, Ed311.02 School Health Services, in order for prescription medications to be given to a student at school, the following is required:

1)
A written statement from the licensed prescriber (physician, ARNP, PA) containing the following: a) student's name, b) name and signature of the licensed prescriber, and business and emergency numbers, c) name, route, and dosage of medication, d) frequency and time of medication administration, e) date of order, f) medical condition requiring medication, if not a violation of confidentiality, g) adverse reactions to be observed for (Physician's Medication Statement form on back). ***An ORIGINAL pharmacy sticker will suffice -OR- you may have your provider complete the "Administration of Prescription Medication-Physician's Medication Statement Form".***

2) Written authorization by the parent/guardian which contains: a) parent/guardian's printed name and signature, home and emergency phone numbers, b) list of all medications student is currently receiving, if not a violation of confidentiality, c) approval to have the school designee assist the student with taking the medication, d) person to be notified in case of a medication emergency in addition to parent/guardian and licensed prescriber.

Complete this form.

3) Parent/guardian or parent/guardian-designated-responsible-adult shall deliver all prescription medication to be administered by school personnel to the school designee. The prescription medication shall be in a pharmacy or manufacturer labeled container. No more than a 30-school day supply of the prescription for a student shall be stored at the school.

The school designee will check medication for complete prescription information, expiration date, original container with pharmacy label and appropriate supply. The medication will be recorded as received and placed in a locked drawer.

I hereby give my permission and request that (child's name)

_____ be assisted by the Concord Christian Academy school designee to receive the prescribed medication (name of medication) _____ during school hours as directed.

Medication: _____ at _____ for
_____. Name of Medication & Dose Time Reason

We the parents, authorize the Concord Christian Academy school designee, to assist our child in taking the said medication and agree that we will not hold liable any member of the school staff who is directed by us (the parents/guardians) and the School Director to assist our child in taking said medication.

Parent/Guardian Name (print)

_____ Home Phone

Parent/Guardian Signature

_____ Work Phone/cell Date

Other medications student is currently receiving

_____ Name of
emergency contact Phone of emergency contact

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Physician's Medication Statement Form

An original pharmacy label may be substituted for the completion of this form.

I hereby instruct the Concord Christian Academy designated member of the School Staff to assist
(Student's name) _____
in taking (dose and route) _____
of (name of medication) _____

at (time) _____ before / with / after
meals (circle one)
for (number) _____ days.

Medical condition of student: _____ . Adverse
reactions to observe for: _____ .

_____ Physician's name
number

_____ Physicians' signature

Physician's phone

Date