MEDICATION ADMINISTRATION FORM

CAMDEN ROCKPORT MIDDLE SCHOOL

Gretchen Kuhn RN, BS School Nurse Phone: 236-7805 ext. 2108 Fax: 236-7815

Student Name: _____Date of Birth: _____ Date:_____

Grade: _____ Teacher: _____

A physician has ordered that my child receive medication during school hours. I am aware that a registered nurse may not be available in each school. Should a nurse not be available, I give my permission for the medication to be given to my child by a school employee who has been properly trained to administer medication to students. I will provide the proper medication in its original prescription container. I am aware that school personnel will not administer medication unless it is ordered by a physician. I give permission for MSAD #28 nursing staff to communicate directly with the prescribing physician regarding the health and medical care of my child.

Parent/Guardian: _____Signature:_____

Contact Information (phone/email)_____

End of Year Medication Disposal (please check off)

Parent/Guardian will pick up _____ School Personnel may dispose _____

TO BE COMPLETED BY PHYSICIAN if medication prescribed for more than 15 days.
(Prescription bottle satisfactory for short-term use)

Known Allergies: _____

Physician Name: _____ Phone: _____

Medication: _____ Dosage: _____

Frequency: _____ Time: _____ Route: _____

Reason for Medication: _____

Student may carry medication (circle one): Yes No

Significant Side Effects: _____

Special Instructions: _____

Physician Signature: _____ Date: _____

THIS FORM AND THE INFORMATION IS CONFIDENTIAL AND MAY NOT BE SHARED WITH ANYONE NOT DIRECTLY ASSOCIATED WITH CARE OF THE STUDENT.