RSU 26 - Orono Schools

Medication Permission Form

I give permission for _____ DOB _____ Grade _____
Print Full Name
to receive the following medication(s) at school.
(RSU 26 requires medication to be in its original container, correctly labeled and transported to and from school by a parent/guardian)

Print Parent Name: _____ Relationship:_____

Parent Signature*: _____ Date: _____ Phone(s):_____
(*Additional Signature required at bottom of form)

PRESCRIPTION MEDICATION

Name of Medication: _____Dose: _____ Time: _____
Route: ____by mouth ____ inhaler ____injections _____Other:_____
Schedule: Med Start Date: _____/_____/_____ Med End Date: _____/_____/_____ or ____PRN (as needed)
Reason for Med: _____
Possible Side Effects: _____
Additional Information/Concerns/Instructions: _____
_____

The following information is only needed if med is not in original med bottle with Dr. info and instructions
Physician's Name and Office: _____
Address:_____Phone: _____Fax: _____
Physician's Signature: _____

NON-PRESCRIPTION MEDICATION (Over the Counter)

Name of Medication: _____Dose: _____ Time: _____
Route: ____by mouth ____ inhaler ____injections _____Other:_____
Schedule: Med Start Date: _____/_____/_____ Med End Date: _____/_____/_____ or ____PRN (as needed)
Reason for Med: _____
Possible Side Effects: _____
Additional Information/Concerns/Instructions: _____
_____

***If Nurse is not available**: An RSU employee who is qualified and willing to administer medications may do so with consent of the parent/guardian, under the guidance of the School Nurse.
Do you give consent for this other qualified person (not the nurse) to administer these meds?

___Yes ___No Parent Signature _____ Date: _____

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School Nurse's Signature: _____Date Received: _____