

PEMBROKE SCHOOL DISTRICT
Pembroke, New Hampshire

ADMINISTRATION OF MEDICATION IN SCHOOL

All students under 18 shall follow regulation Ed. 311.02 approved at the October 21, 1996 meeting of the New Hampshire State Board of Education, which states:

Any pupil who is required to take, during the school day, a medication prescribed by a licensed physician, ARNP or PA shall be supervised by the school nurse or another member of the school staff, so designated by the building principal, and subject to the school district having received and filed with the student health record:

- a. A written statement from the prescribing licensed prescriber, detailing the medication, dose, time and side effects of taking, and the time schedule to be observed.
- b. A written authorization (request) from the parent or guardian of the pupil indicating the desire that the school assist the pupil in the matters set forth in the physician's statement, accompanied by a "hold harmless" release, signed by a parent or guardian.

The exceptions to this policy will be those students who are covered by House Bill 200:42 and House Bill 200:43 which deal with the possession and self-administration of asthmas inhalers and epinephrine auto-injectors. See Addendum B and C

PHYSICIAN'S STATEMENT

I hereby instruct the designated member of the school staff to assist _____
in taking _____
Pupil's name
at _____
Medication dose route time, before, with or after meals
for _____, for the diagnosis/condition of _____ Side effects: _____
Duration _____
Doctor's printed name: _____ Doctor's Signature _____
Date: _____ Doctor's office telephone: _____

PARENT'S OR GUARDIAN'S AUTHORIZATION

I hereby request and give my permission for a designated member of the school staff to assist my child _____ in taking the medication prescribed by _____ and I release said person from responsibility for any adverse effects from the medication or from the effects when my child refuses to cooperate in taking said medication. I also authorize that if necessary, the school nurse and above physician may share information relative to the health of my child.

Date: _____ Parent or Guardian: _____
Signature Parent's printed name
Home Telephone #: _____ Work Telephone #: _____
List other medications child is currently taking: _____
Person to be notified in case of emergency: _____ Telephone: _____
If parent can not be reached, contact: _____ Telephone: _____

Please send only enough medication for one month at a time:

- a. The medication must be delivered directly to the school nurse, principal or teacher by the parent or guardian, or designated responsible adult.
- b. The medication should be delivered in the original prescription container from the pharmacy or the manufacturer's container.
- c. A second prescription bottle containing one day's dose of medication should be provided to the nurse for field trips.

APPROVED: June 10, 2003