MEDICATION FORM FOR MIDCOAST AREA SCHOOLS

RSU 13 Date: _____

Student name: _____Date of birth: _____

School: _____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 non-medical school employee that 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 my permission for RSU 13 personnel to communicate directly with the prescribing physician regarding the health and medical care of my child.

Parent name: _____Signature: _____

Phone: home _____work: _____ cell: _____

MEDICATION ORDER TO BE COMPLETED BY PHYSICIAN

Student's name: _____ Date of birth: _____

Known allergies: _____

Physician name: _____Phone: _____

Medication: _____ Dosage: _____Time to give: _____

Frequency: _____ Reason for medication: _____

Indicators for "as needed" medication: _____

Significant side effects: _____

Special instructions: _____

Physician signature: _____ Date: _____

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