Maine Academy of Natural Sciences Health Services
Nurse: 207-238-4312 Fax: 207-238-4307

REQUEST FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION IN SCHOOL

BEFORE YOUR STUDENT CAN RECEIVE MEDICATION AT SCHOOL (Prescription AND/ OR "over the counter"):

- **This request form must be signed by the student's parent/guardian and physician**. A photocopied, faxed or original written prescription form (such that you would take to the pharmacy to have filled) can be substituted for the physician's signature on this form.
- **All medication must be delivered to the school by a parent/guardian or other adult.**
- **The student's parent/guardian must provide all medication including "over the counter" medications** (such as Ibuprofen or Tylenol).
- For safety, **the first dose of a newly prescribed medication must have been given at home.**
- **Prescription medication must be in a pharmacy-labeled container.** Your pharmacist should be able to provided you with a duplicate bottle when you pick-up the medication. **Over the counter medication must be in the original container and will be administered only as prescribed by the student's physician.**
- **One form is required for each medication** and a new form must be completed to request any changes in this request/order.
- **For medications that are regulated by the Federal Narcotics Act** (please ask your pharmacist or call the school nurse for clarification), **only five days of medication can be kept at school.**
- **For medications not regulated by the Federal Narcotics Act, only twenty days of medication can be kept at school (approximately a 1 month supply).**
- Parents are responsible for removing the medications from school once a medication has been discontinued and/ or at the end of the school year. Unclaimed medications will be destroyed.
- **Students will not be permitted to carry and self-administer any medication** (including overthe-counter medication) **except in the case when an inhaler or Epipen is prescribed for emergency treatment.** Documentation is required and allergy and asthma plans should be on file.

Student: _____ Date of Birth: _____
Allergies: _____ Medication: _____
Dose: _____ Route of Administration: _____
Time to Administer: _____
Reason for Medication: _____
Side effects: _____
Termination Date: _____
What other medications does this student currently take?
_____

Prescribing Physician's Name: _____
Telephone: _____

I understand that the school nurse will provide direction and oversight for the administration of medication in the school. However, when the school nurse is not available, I hereby request and give my consent for unlicensed school personnel trained in medication administration to dispense this medication in accordance with the above instructions.

Prescribing Physician's Signature:_____
Date: _____

Parent Signature: _____
Date: _____

Daytime Parent Contact Phone Number(s):_____