Strong Foundations Charter School

School Health Services 603-225-2715 fax 603-225-2738

PRESCRIPTION MEDICATION ORDER AND PERMISSION FORM TO BE FORWARDED TO SCHOOL NURSE. ***THIS FORM MUST BE SENT DIRECTLY TO SCHOOL NURSE FROM DOCTOR'S OFFICE ONLY.***

TO BE FILLED OUT BY PARENT/GUARDIAN:

Date________________________________

I hereby give my permission to my son or daughter's physician/nurse practitioner____ to release information to Strong Foundations concerning medication(s) prescribed for my son or daughter,____, DOB______________________ and for my above named son or daughter to take the medication as prescribed at school. I will notify the school nurse if there are any changes in medication time or dosage, or if the medication is stopped.

Signature of Parent or Guardian:____

To be filled out by healthcare provider:

Medication____Dosage________________________

Directions/route____

Beginning date:_______________________________Ending date:__________________________

Reason for giving____

Signature of healthcare provider____

Phone Number of healthcare provider_________________________Fax_____________________

To be signed by parent/guarding and health care provider (For rescue inhalers, epi pens and diabetic supplies only):

I hereby give permission for (name of student)__________________________________to carry his/her own (nameof medication)_____________________for his/her (circle one) asthma diabetes mellitus allergy.

Signature of Parent____

Signature of health care provider____

No medication will be given at school until the school receives this completed form with the prescribed medication in a container appropriately labeled by the pharmacy or physician.

All medication brought to school, with the exception of rescue inhalers, epi pens or diabetic supplies, must be kept in the Health Office.

For school use only:

Date received________________Signature of school nurse______________________________