MEDICATION FORM FOR MIDCOAST AREA SCHOOLS

MSAD #28
CRES 239-7809 fax# 236-7820
CRMS 236-7805 fax# 236-7815

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 who 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 any medication unless ordered by a physician. I give my permission for M.S.A.D. 28 nursing personnel to communicate directly with the prescribing physician regarding the health and medical care of my child.

End of Year Medication Disposal: Any medication that is not picked up by parent/guardian will be disposed of properly at the end of the school year.

Parent Name:_____Signature:_____

Phone: Home:_____Work:_____Other:_____

TO BE COMPLETED BY PHYSICIAN if mediation prescribed for more than 15 days
(Rx bottle satisfactory for short-term use)

Student Name:_____Date of Birth:_____

Known Allergies:_____

Medication:_____Dosage:_____Time to give:_____

Frequency:_____Reason for Medication:_____

Student may carry medication: Yes ☐ No ☐

Significant Side Effects:_____

Special Instructions:_____

Physician Name:_____Phone:_____

Physician Signature:_____Phone:_____

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