NEW HARMONY
HIGH SCHOOL

Parent/Guardian Letter of Request and Authorization to
Administer Medication or Medical Procedure

I, _____, request the school nurse or a designated unlicensed trained school staff to administer the medications and/or medical treatments listed on the attached pages to my child, _____. By signing this document I express my understanding and give my permission for the following:

- I give permission to the school nurse or designated, trained unlicensed personnel to administer the listed, prescribed medications or treatments.
- I give permission for my child to self-medicate, if after assessing the student's health status in the school setting, the school nurse or physician determines that the prescribed medication can be taken safely by my child (limited to rescue inhalers and over the counter medications for which we have a written physician order on file)
- I give permission to the school nurse or physician to share medical information about my child with appropriate school personnel. I understand that this information is needed to to fulfill their responsibilities.
- I understand I may retrieve the medication from school at any time and that the medicine will be destroyed if it is not picked up within seven (7) days following the termination of physician's orders or the last day of school.
- I understand that all physician orders must be renewed at the beginning of each school year or as medically necessary.
- I understand that the physician and the parent or guardian are responsible for notifying the school in writing whenever a physician order is written or changes.
- I understand that facsimile (fax) physician/dentist orders are accepted by the school. **Original must follow within three (3) days, this is a State requirement.**
- I understand that I must provide a separate, signed physician order for each medication or procedure to be administered at school.
- I understand it is my responsibility to deliver the medications to school, and to deliver them in the appropriate packaging.
- I understand it is my responsibility to administer the first dose of any new medication and observe for adverse reactions.

_____

Parent or Guardian Signature Date

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Student:_____ Date of Birth:_____
Allergies_____

Medication:_____ Prescription number:_____
Dosage:_____ Route:_____ Frequency:_____
Reason for medication or treatment:_____
_____
Special instructions:_____
_____

Medication:_____ Prescription number:_____
Dosage:_____ Route:_____ Frequency:_____
Reason for medication or treatment:_____
_____
Special instructions:_____
_____

(Please use as many pages as necessary)

Parent or Guardian (please print):_____
Emergency phone number:_____

Secondary emergency contact (please print):_____
Emergency phone number:_____

Physician:_____ Office number:_____
Hospital of preference:_____

Parent or guardian signature:_____ Date:_____