

M.S.A.D. NO.72

**PARENTAL PERMISSION**  
**FOR MEDICATION ADMINISTRATION**  
**AT SCHOOL**

\*Written parental permission is required for medications to be administered at school.

**Student Name** \_\_\_\_\_ **Grade/Teacher** \_\_\_\_\_

Prescribing Physician Name: \_\_\_\_\_ Physician's Tel.# \_\_\_\_\_

Name of Medication: \_\_\_\_\_

*(If this is a prescription medication, you will need to provide a doctor order for this medication to be administered at school)*

Purpose of Medication: \_\_\_\_\_

Dosage of Medication: \_\_\_\_\_

Time Medication is to be Administered: \_\_\_\_\_

Possible Side Effects of this Medication: \_\_\_\_\_

Start Date for Administering Medication: \_\_\_\_\_

Termination Date for Administering Medication: \_\_\_\_\_

***I give my permission for:***

- a. *The School Nurse or trained unlicensed school personnel to administer the above medication at school to my child.*
- b. *The School Nurse to share with appropriate school personnel information regarding the student medication when needed.*
- c. *The School Nurse to provide and obtain needed medication information from the prescribing physician and/or health care provide when needed.*

***I will/have asked my child's physician to send or FAX the order for my child to receive prescription medication at school; I understand the prescription medication will not be administered if the doctor order is not received.***

**Send to:** Nancy Boucher RN, BSN – School Nurse  
MSAD #72  
25 Molly Ockett Drive  
Fryeburg, ME 04037  
Tel. # 207-935-2401 Ext. 1248 Fax # 207-935-4470

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Home Tel./Cell Phone # \_\_\_\_\_ Work Tel. # \_\_\_\_\_