

Merriconeag Waldorf School

PERMISSION & RELEASE: Administration of Medication

This Permission and Release applies to Merriconeag Waldorf School Officials, Staff, Volunteers and Other Representatives during school and in connection with school activities¹

*Each Medication Requires a Separate Form

Student Name: _____ DOB: _____ Grade: _____ Teacher: _____

Name of medication: _____

Reason for medication: _____

Type of medication/treatment:

Tablet/capsule Liquid Inhaler Injection Other

Instructions during school day: Dose _____ Frequency _____

Start: date form received Other date _____

Stop: end of school year Other date/duration _____

Special instructions/or important side effects: None Yes, please describe below:

Special storage requirements: None Refrigerate Other : _____

The administration of this medication during the school day is necessary for the student's health and attendance in school. It is recommended that the first dose of a newly prescribed medication be given at home.

This student has the knowledge and skill to carry and self-administer this medication
(epi-pens/inhalers only) Yes No

Physician's Name: _____

Physician's Signature: _____

Phone number: _____

I am not available to dispense the above named medication during school hours and/or while the student listed above is participating in a school activity. I understand that this will be administered by non-medical personnel, volunteers, and/or other representatives of the Merriconeag Waldorf School

¹ School activities include activities offered by the school before during and after school, as well as on the weekends and during summer and vacations, as well as any travel and transportation associated with the activities. They include, but are not limited to, field trips extracurricular activities, athletic programs, school-wide outings, student competitions and school fairs and celebrations.

Permission to Contact Prescribing Health Care Provider

I give my permission for MWS to contact the above named prescribing health care provider to obtain information about the medication and the administration schedule. I give my permission for the school nurse and/or administration to share information with the prescribing health care provider about the effects of the medication on my child's learning.

Medication Removal

I understand that I must remove any medication no longer required or that remains at the end of the school year or it will be disposed of.

The following is recommended by the lawyer, but we've required a physician's signature even for this med. (see box on page one). I would like to keep what we have and delete the following. As you wish.....

My child may carry and self-administer this medication (epi-pens/inhalers only) Yes No

Parent or Legal Guardian Signature: _____ Date: _____

Telephone (home): _____ (Work): _____