Barbara A. Neilly
Principal

Conners Emerson School
11 Eagle Lake Rd
Bar Harbor, ME 04609
(207)288-3631

Heather Webster
Assistant Principal

Medication Administration Request

Name of Student:_____ Date of Birth:_____

PART I: PARENT/GUARDIAN/RESPONSIBLE PERSON AUTHORIZATION AND CONSENT

Parent/Guardian/Responsible Person: Please complete and sign this section.

I hereby request and authorize the School Nurse/Trained School Employee to administer prescribed medication as directed by the licensed practitioner to _____ . This medication is a ____ new (or) ____ renewal prescription.

Name of Student

If new prescription, enter the date and time the first dose was given at home, first dose can not be given at school. Date:_____ Time:_____ a.m./p.m. I am aware that Conners-Emerson School has only one school nurse on staff who can not provide personalized nursing services to students. However, the above named student is in need of the above named medication during regular school hours to maintain his/her physical and or mental health. In my opinion, the above named medication is so important that if the school nurse is not available, I advise and request that the medication be administered by appropriate trained school personnel.

_____ _____ _____

SIGNATURE OF PARENT/GUARDIAN/RESPONSIBLE PERSON RELATIONSHIP HOME PHONE

_____ _____ _____ _____

PRINT NAME WORK/CELL PHONE E-MAIL ADDRESS DATE

PART II: LICENSED PRACTITIONER'S AUTHORIZATION FOR MEDICATION

Physician/Nurse Practitioner: Please complete and sign this plan. ____New ____Renewal ____Change

NAME OF STUDENT:_____ DATE OF BIRTH_____
NAME OF MEDICATION_____ DOSE & ROUTE _____
TIME AND FREQUENCY OF ADMINISTRATION AT SCHOOL_____DIAGNOSIS:_____
EXPECTED DURATION OF SCHOOL ADMINISTRATION:_____
Can a reaction be expected? ____YES ____NO If Yes, please describe possible side effects
_____
Special instructions for administration: _____
_____
_____

Medication plans must be updated and the school nurse immediately notified when there is any change in the student's health or treatment requirements. Otherwise, medication plans must be submitted annually.

LICENSED PRACTITIONER SIGNATURE

_____

PLEASE PRINT NAME_____

OFFICE PHONE _____DATE _____

Part III: SCHOOL NURSE

Medication Plan authorization received by_____

Signature of School Nurse

Date_____