SAU #39 Amherst, NH

Clark Elementary	Wilkins Elementary	Mont Vernon	Amherst Middle	Souhegan High
673-2343	673-4411	673-5141	673-8944	673-9940

MEDICATION AUTHORIZATION/ADMINISTRATION FORM

PRN- AS NEEDED MEDICATIONS

All prescription medications require written authorization from BOTH a primary care provider (physician, nurse practitioner, physician's assistant) and parent or guardian. Written authorization from a parent or guardian must be provided for any over the counter medication. Over-the-counter medications (including homeopathic) prescribed under any of the following conditions require a primary care provider and parent signature:

1. Over-the-counter medications prescribed for treatment of a chronic condition: Migraines, allergies, Cystic Fibrosis, Diabetes, Lactose Intolerance, and Gastrointestinal Disorders.
2. Asthma inhalers and emergency use Epi-pens or Anakits for known allergies must be accompanied by a doctor's order to carry and self-administer, or can be secured in the Nurse's Office.
3. Prescribed to be dispensed other than by the package directions

Student's Full Name ____________________________________Teacher/Grade_____________________

Reason for Medication: ____

Medication Name: ____

Dosage: ____

Frequency/Time: ____________________________ Side Effects: ________________________________

Duration/Expiration Date: ________________ Physician's Signature __________________________

I certify to the best of my knowledge that my child is not allergic to this medication. I agree to hold harmless the Amherst School District from any responsibility for any harmful side effects that may occur as a result of my child taking the above-named medication.

Parent Signature: ____ Date ___________________

Date	**1**	**2**	**3**	**4**	**5**	**6**
Time:						
Dose						
Comments						
Signature						
Date	**7**	**8**	**9**	**10**	**11**	**12**
Time:						
Dose						
Comments						
Signature						

Sign here for permission for student to carry and self-administer their inhaler and/or adrenaline injectable kit.

Physician's Signature ____________________________________ Parent's Signature ____________________________________

Date	13	14	15	16	17	18
Time:						
Dose						
Comments						
Signature						
Date	19	20	21	22	23	24
Time:						
Dose						
Comments						
Signature						
Date	25	26	27	28	29	30
Time:						
Dose						
Comments						
Signature						
Date	31	32	33	34	35	36
Time:						
Dose						
Comments						
Signature						
Date	37	38	39	40	41	42
Time:						
Dose						
Comments						
Signature						

A/D	Nurse's/Staff Member's Signature	Initials	A/D	Nurse's/Staff Member's Signature	Initials

A = Assisted/Supervised Student taking own medication
D = Dispensed medication to student