MEDICATION FORM FOR MIDCOAST AREA SCHOOLS

M.S.A.D. 28 / Five Town Community School District
Fax No. 236-7813

Date: _____

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

A physician has ordered that my child receive medication during school hours. I am aware that a registered nurse may not be available in each school. Should a nurse not be available, I give my permission for the medication to be given to my child by a non-medical school employee who has been properly trained to administer medication to students. I will provide the proper medication in its original prescription container (other than acetaminophen or ibuprofen). I am aware that school personnel will not administer medication unless it is ordered by a physician. I give my permission for M.S.A.D. / CSD personnel to communicate directly with the prescribing physician regarding the health and medical care of my child.

End of Year Medication Disposal (please check off)

Parent/Guardian will pick up ☐
School Personnel may properly dispose locally ☐

Any medication that is not picked up by parent/guardian will be disposed of properly.

Parent Name: _____Signature: _____

Phone: Home: _____ Work: _____Other: _____

TO BE COMPLETED BY PHYSICIAN if medication prescribed for more than 15 days
(Rx bottle satisfactory for short term use)

Known Allergies: _____

Physician Name: _____ Phone: _____

Medication: _____ Dosage: _____ Time to give: _____

Frequency: _____ Reason for Medication: _____

Student may carry medication: Yes ☐ No ☐

Significant Side Effects: _____

Special Instructions: _____

Physician Signature: _____ Date: _____

THIS FORM AND THE INFORMATION THEREON IS CONFIDENTIAL AND MAY NOT BE SHARED WITH ANYONE NOT DIRECTLY ASSOCIATED WITH CARE OF THE STUDENT.

2/08