Wilton-Lyndeborough Cooperative School District
School Administrative Unit # 63

192 Forest Rd Lyndeborough, NH 03082
603-732-9227

Peter Weaver	Ned Pratt	Kristie LaPlante
Superintendent of Schools	Director of Student Support Services	Business Administrator

MEDICATION AUTHORIZATION/ADMINISTRATION FORM

Check which school student will attend

GRADES: PRE-K - KINDERGARTEN	***GRADES: 1 – 5***	***GRADES 6-12***
☐ ***LYNDEBOROUGH CENTRAL SCHOOL***	☐ ***FLORENCE RIDEOUT ELEMENTARY SCHOOL***	☐ ***WILTON-LYNDEBOROUGH COOPERATIVE MIDDLE SCHOOL/HIGH SCHOOL***
192 Forest Road	18 Tremont St	57 School Rd
Lyndeborough, NH 03082	Wilton, NH 03086	Wilton, NH 03086
Phone: 603-732-9228	Phone: 603-732-9229	Phone: 603-732-9230
FAX: 603-654-6884	**FAX: 603-654-3490**	**FAX: 603-654-2104**

THIS FORM MUST BE COMPLETED BY BOTH THE HEALTH CARE PROVIDER AND PARENT/GUARDIAN

1. A signed physician form is required for any prescription medication given during the school day
2. Over-the-Counter medication prescribed with the following conditions:
   A. For a chronic condition (Ex. Migraine headaches, allergies, GI Disorders, etc.)
   B. For a period lasting longer than 2 weeks
   C. To be dispensed contrary to the package directions (ed. Adult dose for a child, etc.)

HEALTH CARE PROVIDER SECTION

Student's Full Name: ______________________ *DOB* ____________

Diagnosis/Reason for Medication: ______________________

Name of Medication ____________ *Dosage* ____________ *Frequency/Time* ____________

Side Effects ______________________

THE ABOVE NAMED STUDENT ☐ ***Is*** ☐ ***Is Not*** CAPABLE OF SELF-ADMINISTERING THEIR OWN MEDICATION

HE/SHE: ☐ ***MAY*** ☐ ***MAY NOT*** CARRY THEIR OWN INHALER OR EPIPEN

Duration/Expiration Date: ____________ ***Physician's Signature*** ____________ ***Date*** ____________

PARENT SECTION

Parent/Guardian will deliver all medication(s) directly to the school nurse.
All medications must be stored in their original pharmacy or manufacturer's labeled container.
The school nurse will verify medication quantity and accuracy of emergency contact information each time a medication is delivered to the school.
Prescription medication will only be given when appropriate documentation is completed by their provider and parent/guardian.

I hereby request that my child be assisted in taking the above medication(s) as ordered by their provider. I release SAU63 and all its employees from any and all liability for any side effects that may occur as a result of this request.

Parents/Guardian Signature ______________________ *Date* ____________

Emergency Contact Number(s) ______________________