



North Yarmouth Academy

Authorization for Administration of Medication by School Personnel:

To the Physician: Attached signed prescription accepted in lieu of completion of physician portion

Student: _____ Grade: _____

Medication: name, dose and frequency: _____

Possible side effects and significant medical information: _____

Physician Signature: _____ Date: _____

Address: _____ Telephone: _____

To the parent:

I hereby give permission for designated North Yarmouth Academy employees to administer or monitor self-administration of the above authorized medication to: _____

I further understand that it is my responsibility to furnish this medication and any authorized refill. I understand that North Yarmouth Academy, its officers, agents, and/or any school employee who administers the medication to my child, in accordance with written instructions from the prescribing physician, shall not be liable for damages as a result of an adverse drug reaction or any other injury suffered by my child due to the administration or failure to provide the drug. The school reserves the right to not administer the medication should circumstances warrant such action. In such a circumstance the parents/guardian are to be notified as soon as possible.

I understand that all medication provided to the school must be in the original pharmacy container, properly labeled with the students name, medication name, dosage and frequency. Location is designated below with the approval of the Health Service Office (school nurse or designee)

Medication location: Scheduled Emergency/back-up Other

- Health Service Office:
- Student:
- Off Campus designee:

Comments: _____

I acknowledge that I agree with the above statement and will comply with its requirements.

Signature of Parent/Guardian _____ **Date:** _____

Reviewed by school nurse/designee: _____ **Date:** _____