

**Mt Ararat High School
73 Eagles Way
Topsham ME 04086
729-2951 ext 264**

Permission to Administer Medication in School

Student's Name _____ D.O.B. _____ Grade _____

Name of Medication _____ Dose _____

Name of Physician Prescribing Medication _____

Reason for Medication _____

Side Effects _____

Time Medication to be Administered _____

Physician Signature _____

I give permission for designated school personal to administer the required medication to the student named above. I understand that MSAD #75 discourages the administration of medicines on school premises. I realize that the school nurse may be responsible for more than one school site and may not always be available to administer the medication. I know that when possible medication should be given at home before and after school hours. I also realize that it is the responsibility of the student to take his medication at the prescribed time. It is not the responsibility of the school to remind the student.

Signature of Parent/Guardian: _____

Date _____