MECDHH/GBSD Medication Form

2019-2020 School Year

Phone: 781-6215/Fax: 781-6246

****Print this form and fill out with your physician.****

Once completed email to: maryjo.york@mecdhh.org, fax to: 781-6246

or mail to: MaryJo York, MECDHH/GBSD, 1 Mackworth Island, Falmouth, ME 04105

Student's Name:_____DOB:_____

TO BE FILLED OUT BY PHYSICIAN:

Physician's Name (Please Print): _____

Reason for Medication: _____

Name of Medication: _____

Directions (include specific area of application if topical):

If PRN, frequency: _____ Max dose in 24 hours: _____

Date of Discontinue: _____ (not to exceed school year)

Side effects and action to be taken:

❑ Student may carry inhaler with them throughout the school day

❑ I request and give my permission for school personnel, under the direction and at the discretion of the school nurse, to administer this medication to the above-named student

❑ Student may self-administer this medication under the supervision of trained school personnel

Physician's Signature _____ Date: _____

Physician's Tel. # _____Date: _____

TO BE SIGNED/DATED BY PARENT/GUARDIAN:

❑ Student may carry inhaler with them throughout the school day

❑ I request and give my permission for school personnel, under the direction and at the discretion of the school nurse, to administer this medication to the above-named student

❑ Student may self-administer this medication under the supervision of trained school personnel

Parent/Guardian Signature _____ Date: _____