DERRY COOPERATIVE SCHOOL DISTRICT, SAU 10
OFFICE OF THE SCHOOL NURSE

DERRY VILLAGE SCHOOL	432-1233
EAST DERRY MEMORIAL SCHOOL	432-1260
ERNEST P. BARKA ELEMENTARY SCHOOL	434-2430
GILBERT H. HOOD MIDDLE SCHOOL	432-1224
GRINNELL ELEMENTARY SCHOOL	432-1238
SOUTH RANGE ELEMENTARY SCHOOL	432-1219
WEST RUNNING BROOK MIDDLE SCHOOL	432-1250

NOTE TO PARENTS:
The school is required by law to have on file an order from your child's physician authorizing the administration of named medication. Without this your child cannot receive medication during school hours. The physician's order is valid for one school year.

A new order must be written each time the medication is changed.

TO THE PHYSICIAN:

Name of Pupil:_____

Diagnosis: _____

Medication to be given:_____

Dosage:_____Time:_____Duration:_____

Physician's Signature Required:_____

Physician's Name (print/stamped):_____

PARENTS PLEASE NOTE:
Medication must be in the original pharmacy labeled container. In order to do this request an extra bottle from the pharmacist.

PARENTAL PERMISSION 'HOLD HARMLESS STATEMENT'
We, the parents, authorize the School Administrator to direct members of the school staff to assist our child in taking oral medication and/or medicine by injection, and agree that we will not hold liable any member of the school staff or an individual or official capacity who is directed by us (the parents) and the School Administrator to assist our child in taking the prescribed medication according to the directions indicated above.

I hereby consent to communication and exchange of information between the above mentioned doctor and my child's school principal, school nurse, or classroom teacher(s) regarding health issues that may impact on his/her performance at school.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian's Name Printed

Approved 09/2005