School Name: ______________________________

School Fax: ______________________________

EE

Manchester Health Department
1528 Elm St.
Manchester, NH 03101
Tel: (603) 624-6466

MANCHESTER HEALTH DEPARTMENT & SCHOOL DISTRICT MEDICATION OR PROCEDURE ORDER FORM

STUDENT NAME: ____ D.O.B: ____________

PARENT/GUARDIAN: ____

ADDRESS: ____ PHONE #: _____________

TO BE COMPLETED BY HEALTH CARE PROVIDER:

DIAGNOSIS: ____

MEDICATION/PROCEDURE: ____

____

DOSAGE: _______________________________________ ROUTE: _______________________

TIME OF ADMINISTRATION: ____

SPECIAL INSTRUCTIONS (Optional): ____

____

PRESCRIBED BY: ____ DATE: _____________
(Signature of Health Care Provider)

Print name: ____ Providers Phone #: ____________

PARENT / GUARDIAN PERMISSION

I hereby authorize the designated staff person to administer the above-prescribed medication/procedure according to the directions. In consideration for this service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise save harmless, the City of Manchester and/or any department or employee thereof for any death or injury resulting from the administration or assistance in the administration of the medication described above.

Signature of parent / guardian: ____ Date: _________

Field Trip:

Option: ***I*** ☐ ***do*** ☐ ***do not*** wish to have my child's medication administered by designated staff person on a field trip. ☐ Initials in box
(initials in box please)

(Optional Release - Signature Required)

I hereby authorize that, if necessary the school nurse and above physician may share information relative to the health of my child (name) ____.

Parent /Guardian Signature ________________________________ Date: ______________