

LITTLETON PUBLIC SCHOOLS

PRESCRIPTION MEDICATION FORM

Name of student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

*(To be completed by a Licensed Prescriber)*

Name of Prescriber \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone \_\_\_\_\_

Medication(s) \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_

Frequency \_\_\_\_\_ Time of Administration \_\_\_\_\_

Specific directions or information for administration \_\_\_\_\_  
\_\_\_\_\_

Allergies \_\_\_\_\_

Side effects, contraindications, adverse reactions \_\_\_\_\_  
\_\_\_\_\_

If applicable:

Has student been trained in proper use of Inhaler/Epipen? Yes \_\_\_\_\_ No \_\_\_\_\_

Is student authorized to carry and to self-administer Inhaler/Epipen? Yes \_\_\_\_\_ No \_\_\_\_\_

Date medication to begin \_\_\_\_\_ Date medication to end \_\_\_\_\_

Licensed Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

**MEDICATION MUST BE PROVIDED IN ORIGINAL PROPERLY LABELED CONTAINER**

I request that my child be assisted in taking the medicine(s) described above at school by the school nurse or permitted to self-medicate(inhaler/epipen) as also authorized by myself and my physician. I have been fully informed concerning the use and effects of the medication, and I hereby release, indemnify, and hold harmless the Littleton Public School System and Committee, its employees and agents concerning any and all liability which may arise in connection with the administration of this medication.

\_\_\_\_\_  
Date Parent/Guardian signature Home phone Cell phone