Gorham Middle & High School
120 Main Street
Gorham, NH 03581
(603) 466-2776

AUTHORIZATION TO RELEASE PHYSICAL AND IMMUNIZATION RECORDS

Student's Name _____ Date of Birth _____

I release and authorize Coos County Family Health Services or my PCP to release healthcare information of the patient named above to:

School Nurse, Gorham Middle & High School

This request and authorization applies to Immunization and Physical information for the above named student.

Parent's Signature _____ Date _____

Gorham Randolph Shelburne Cooperative School District
Stock Medication Permission Form

We, the parent(s) / legal guardian of _____ authorize the school nurse or other designated school personnel to assist my child in taking the following medication(s) during the school day as needed. The school nurse, if available, will evaluate your child prior to administering the medicine. The medication will be given only once during the school day for minor complaints. Any repeat request will be denied. A note will be sent home with the student to notify you that a medication was given during the school day. Unless otherwise stipulated, acetaminophen will be given for headaches and ibuprofen will be given for musculoskeletal discomfort or inflammation. Dosages will be determined by the instructions on the package. Any variation to the recommended dose will require a separate permission slip. Stock medication will not be dispensed unless this form is signed and on file in the nurse's office each school year.

Please check the medications(s) that you authorize the school to make available as needed:

- ☐ Acetaminophen (non-aspirin) for generalized discomfort
- ☐ Antacid for stomach upset
- ☐ Hydrocortisone 1% cream for minor itching
- ☐ Ibuprofen for generalized discomfort.
- ☐ Bacitracin ointment for minor cuts
- ☐ Oral antihistamine for allergy symptoms.
- ☐ Burn gel for minor burns
- ☐ Cough drops
- ☐ Sore throat Lozenges
- ☐ Lotion for dry or cracked skin.

Please list any restrictions that you may have:

_____

_____

Hold Harmless Law Under Provision RSA 541:A

We, the parent(s)/legal guardian authorize the school administrator to direct members of the school staff to assist our child in taking oral medication and agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by us (the parent(s)/legal guardian) and the school administrator to assist our child in taking said oral medication.

_____ Parent/Guardian Signature

_____ Date

_____ Printed Name

_____ emergency phone #'s

Alternative contacts and numbers:

_____

Please note: If you would like your child to have any other medications or any other form of these medications (liquid, dissolve tabs), please send in the medication from home in the original container, with a note and the medication will be held in the health office. The note will suffice for 24 hours. After that, the medication permission form provided by the school will be required.

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For Office Use Only

Grade _____

Teacher _____

School Health Services
PARENT'S REQUEST TO GIVE MEDICATION AT SCHOOL

I request the school assist my child _____ in receiving the

following medication: _____.

If prescribed: Doctor _____ Pharmacy _____

Diagnosis _____

Dosage _____ Time _____

Beginning on _____ Ending on _____

According to New Hampshire Law: The medication must be delivered to the school nurse, principal, and/or the designee. It must be in the original container properly labeled (pharmacy label) with student's name, physician's name, date of original prescription, and the name of the medication. Over-the-counter medicine must be in the original container.

For medicines prescribed by a physician, a written statement from the physician detailing the administering of medication should accompany this request.

HOLD HARMLESS STATEMENT

We, the parent(s)/legal guardian authorize the school administrator to direct members of the school staff to assist our child in taking oral medication and agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by us (the parent(s)/legal guardian) and the school administrator to assist our child in taking said oral medication.

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

We, the parent(s)/legal guardian, give permission to the school nurse to release this medical information to the necessary school personnel on a need-to-know basis such as the classroom teacher, P.E. teacher, etc.

☐ Yes ☐ No

_____ _____
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

_____ _____
PRINTED NAME EMERGENCY PHONE #S

Alternative contacts:

_____

Please list any other medicines your child is taking:

_____