



The Lyme School

Kindergarten to Eighth Grade Serving the community of Lyme, New Hampshire for over 100 years
(603) 795 - 2125 • MAIN STREET, LYME, NEW HAMPSHIRE 03768

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 Town of Lyme 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
(initials in box please) person on a field trip. Initials in box

(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: _____