The Counseling Center of Nashua

CONSENT TO ADMINISTER MEDICATION

DATE: _____ Acct #: _____ Provider: _____

PATIENT NAME: _____ PATIENT'S DOB: _____

I _____,
Printed Parent/Legal Guardian Full Name

authorize _____ to administer the following medication(s)
Full Name of School

_____	_____**mg**	_____
Medication	**Dosing**	**Time of Day**
_____	_____**mg**	_____
Medication	**Dosing**	**Time of Day**
_____	_____**mg**	_____
Medication	**Dosing**	**Time of Day**

The following signed release to administer the above medication(s) is in effective for the following period of time:

_____ to _____ **OR**

_____ Duration of the Current School Year

NOTE: THE TOP PORTION OF THIS FORM MUST BE COMPLETED PRIOR TO PROVIDER SIGNING THIS DOCUMENT

This medication is currently being prescribed by the following provider

_____ _____
Provider Signature **Date**

I understand that by signing this release, I am allowing my child's school nurse to contact the provider listed on this form, should he/she have need any questions answered to the clarification of the medication or dosage listed above. I also understand that as the Parent/Guardian of the above child, I may revoke this release at any time by doing so in written notification to The Counseling Center of Nashua.

_____ _____
Parent /Guardian

Mailing Address: 1 Main Street Nashua NH 03064
Phone: 603.883.0005 Fax: 603.883.0007
Please direct any inquires to the Records Department (ext. 307)