

The doctor can fill out this form, or you can call and ask them to fax Dr. Orders and an emergency plan to:  
603-424-6208 ATTN: NURSE

**Merrimack School District**  
**PRESCRIPTION AUTHORIZATION FORM**  
**MEDICAL PROVIDER SECTION FOR ALL PRESCRIPTION MEDICATIONS**  
**(to be completed by the student's medical provider)**

Student Name: \_\_\_\_\_ Date Prescribed: \_\_ Duration of  
Prescription: \_\_\_\_\_  
Diagnosis/Indications for Administration: \_\_\_\_\_  
Medication(s): \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Daily Time of  
Administration/or PRN: \_\_\_\_\_ Frequency: \_\_\_\_\_  
If PRN Describe Indication(s) for Administration: \_\_\_\_\_  
Side Effects/Intervention for Adverse Reactions: \_\_\_\_\_  
Other Information: \_\_\_\_\_

**Attach Asthma Action Plan or Diabetes Plan if it applies to the student**

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Contact Number:** \_\_\_\_\_

**AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION  
DURING SCHOOL HOURS (Epi-pen, Insulin/Insulin Pump and/or Inhaler only)**

I have instructed the above student in the use of his/her Epi-pen, Insulin, Insulin Pump and/or Inhaler and he/she may carry the medication on his/her person and self-administer medication as instructed by me and prescribed on the Prescription Authorization Form during school hours.

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Contact Number:** \_\_\_\_\_

**PARENT/GUARDIAN REQUEST FOR SELF-ADMINISTRATION OF  
EPI-PEN, INSULIN, INSULIN PUMP, AND/OR INHALER**

This section must be completed and signed before the student will be permitted to self-administer medication. **The Prescription Authorization Form must also be completed by the student's medical provider and must be on file in the Health Office.**

**All boxes must be initialed:**

- \_\_\_\_\_ I request that my child be permitted to carry and self-administer his/her Epi-pen, Insulin Pump, Insulin, or inhaler at school, as authorized by his/her medical care provider on the Prescription Authorization Form.
- \_\_\_\_\_ I accept responsibility for making sure that my child carries the drug at all times.
- \_\_\_\_\_ I hereby release the Merrimack School District, The Merrimack School Board, and its agents and employees from all liability, claims, and causes of action for injuries resulting from my child's self-administration of medication, including my child's misuse of or failure to administer the medication.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_