LAKEVIEW LOCAL SCHOOL DISTRICT

Parental Request for Administration of Prescribed Medication

To the Parent:

The following information is necessary for any student to receive physician-prescribed medication on school premises. The **FRONT** and **BACK** of this form must be completed for each medication.

____ ____________________ ________

Name of Student Birthdate Age

____________________________________ ________________ ____________________

School Grade Homeroom Teacher

1. I am requesting permission for my child named above to receive physician prescribed medication at school.
2. I will assume responsibility for the safe delivery of the medication to school for the initial and all subsequent doses, for maintaining adequate amounts of medication, and replacing it prior to its expiration date.
3. I will provide the school with a new Medication Authorization form if there is any change in the dosage or use of the medication, and I will notify the school in writing if the medication is discontinued. I understand that verbal notification is permissable followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability for damages or injury resulting directly or indirectly from this authorization, in accordance with the Medication policy.

____________________________________ ____________________________

Signature of Parent/Guardian Relationship to Student

__________________________ ______________________ ________________

Home Telephone Work Telephone Date

LAKEVIEW LOCAL SCHOOL DISTRICT

Physician Statement for Prescribed Medication

To the Physician:

The Board of Education urges you to schedule, to the extent possible, the administration of medication to a student outside of school hours. When that is not possible, medications will be permitted, insofar as feasible, during school hours. Please complete every space.

____ is under my care. I have prescribed
Name of Student

____
Name of medication, dosage, route of administration

____
Time(s) to be given

Beginning date:___________________________ Expiration date:_________________________

Specific instructions for
administration:____

FOR EMERGENCY MEDICATION ONLY (please check):

Child is to carry medication_______ Child is to report to the clinic for the medication_______

Possible side effects to watch for:____

Side effects to report to physician:____

Specific instructions including storage/sterility:____

Allergies:____

Physician Signature:____

Printed/Typed Physican Name:________________________________

Physician Telephone:______________________

Date:___________________