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:_____