Our Lady of the Blessed Sacrament School – Lancaster Central School District

PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:

Child's Name________________________________ **Grade**__________ **Date of Birth**____________

- I request that my child receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the **properly labeled, original container** from the pharmacy.
- I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

____ ____
Signature (Parent or Guardian) **Please Print Name**

____
Address City State Zip

_________________________ _______________________ _______________________
Telephone No. Work Telephone No. Date

B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:

*** I request that my patient, as listed above, receive the following medication**:

Medication:______________________________________ Diagnosis:__________________________________

Dose:___________________ Frequency:__________________ Route of Administration:________________

Time:____ Duration of Treatment:_____________________

Possible Side Effects and Adverse Reactions (if any): ____

____

Other Recommendations: ____

Should student take medication on field trip? __________Yes __________No
If no, should medication be omitted for the day: __________Yes __________No

____ ____
Name of Licensed Prescriber & Title (please print name) **Prescriber's Signature**

____ ___________________
Address City Phone No. Date

C. NOTE: This section must be signed, in addition to the above District Medication Form, for those students who request permission to carry their own medication on campus or keep this medication in a locker.

SELF MEDICATION RELEASE FORM

_________________________________(child's name) has been instructed in the proper use of the following medication

procedures:____

We request that he/she be permitted to carry the medication on his/her person or to keep same in his/her locker or p.e. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

____ ____
Physician's Signature Parent's Signature