AUTHORIZATION TO GIVE MEDICATION

LINCOLN TRAIL DISTRICT HEALTH DEPARTMENT

STUDENT ______________________________ BIRTHDATE ______________

ALLERGIES ____

Medications will be given at school only with written permission from the child's parent or guardian. Prescription medications must have the written permission from the Health Care Provider to administer. The medication must be in the original bottle with pharmacy label as proof of Health Care Provider prescription. Signed permission will expire at end of the school year.

I hereby request that school personnel give the medication described below to my child:
These instructions should be followed in giving my child this medicine:

Name of Medicine ______________________

Dosage ______________________

Time of Day for Dose ______________________

Reason Medicine is to be Given ______________

Possible Reactions or Side Effects ___________

____

Prescribing Primary Care Provider: ______________________

Address: ______________________

Phone: ______________________

Note: Over the counter medication should be in the original container, dated upon receipt, and given no more than three consecutive days without written permission from the Health Care Provider.

I hereby give permission for myself/my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of the school or LTDHD as a result of administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the request for medication to be followed. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and the LTDHD School Nurse regarding my child's medical regime.

Parent/Guardian Signature ______________________________ Date ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________