MEDICATION ADMINISTRATION FORM

Student: ____ Grade: _______ DOB: ____________________

Address: ____

Name of Guardian(s): ____

Home Phone: _________________________ Cell Phone: _________________________ Work Phone: ________________________

Please list any allergies and/or medical conditions: ____

Height: _________ Weight: _________ Gender: _________ Emergency Contact: ____

Relation to student: ___________________________________ Emergency Contact Phone: _________________________________

Name of preferred hospital (in event of a medical emergency): ____

Name of Physician: _______________________________________ Physician's Phone: _____________________________________

Medication: ____

Dosage/Frequency: __________________________________

Time of administration: _______________________________

Special Instructions: __________________________________

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Medication: ____

Dosage/Frequency: __________________________________

Time of Administration: _______________________________

Special Instructions: __________________________________

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Medication: ____

Dosage/Frequency: __________________________________

Time of administration: _______________________________

Special Instructions: __________________________________

____

____

Medication: ____

Dosage/Frequency: __________________________________

Time of Administration: _______________________________

Special Instructions: __________________________________

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I hereby request that my child be administered his/her prescribed medication(s) at school by school personnel. I understand that the medication will be administered in accordance with the LHSA board policy and the instructions of my above named physician.
I will notify the school of any changes and/or discontinuation of this medicine.

Parent/Guardian Signature: ____ Date: ____________________

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Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary prescribed medication to students for limited periods of time. NO hypodermic injections will be given. All medications must be in the original container, clearly labeled, and indicating the following information: the student's name, dosage, doctor's name, date issued, and the time it should be administered.

I do hereby request and authorize that the prescribed medication listed on the previous page be given to my son or daughter,

(Student's Name)____, as indicated by the prescribing physician.

Parent/Legal Guardian Signature: ____ Date: ___________________

Date	Time Given	Administered By	Medication/Dosage	Reason for Administration