SCHOOL DISTRICT OF LADYSMITH
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

PRESCRIPTION MEDICATION

Name of Student: _____Birthdate: _____

Parent/Guardian: _____Phone: _____

Address: _____

School: _____Grade: _____Teacher: _____

Part I - Physician's Statement

1.Reason for medication _____

2.Name/type of medication _____

3.Dosage/amount to be given _____

4.Frequency/times to be administered _____

5.Duration (week, month, indefinite, etc.) _____

6.Possible reaction to medication (side effects, symptoms, etc.)

_____

7.Contact me should the following occur _____

_____

Physician's Signature Address Phone Date Signed

Part II - Parent's/Guardians Request for Approval:

I hereby request and give my permission for the above-named school to administer the medication prescribed on this form to my child, and I authorize them to contact the child's physician, if necessary. I further exonerate the School District of Ladysmith from any liability resulting there from. I shall inform the school of any change in the child's health or medication.

_____

Parent's/Guardian's Signature Date Signed

Part III - Designated Person(s) Administering Drugs

I have agreed to administer the medication as requested by the parents/guardians and in accordance with directions listed above by the physician.

_____

Signature of Person(s) Administering Medication Date Signed

IT IS THE POLICY OF THE SCHOOL DISTRICT OF LADYSMITH THAT MEDICATION BE BROUGHT TO THE SCHOOL IN THE ORIGINAL CONTAINER. ANY MEDICINE NOT IN THE ORIGINAL CONTAINER WILL NOT BE DISPENSED TO ANY STUDENT.