



**LAKELAND JOINT SCHOOL DISTRICT #272**

**15506 N. Washington Street P.O. Box 39**

**Rathdrum, Idaho 83858**

**Phone: 208.687.0431 Fax: 208.687.1884 Web: lakeland272.org**

**AUTHORIZATION FOR MEDICATION ADMINISTRATION**

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

1. Physician's name and phone: \_\_\_\_\_
2. Name/type of medication: \_\_\_\_\_
3. Dosage/amount to be given: \_\_\_\_\_
4. Frequency/times to be administered: \_\_\_\_\_
5. Possible reaction to medication ( side effects, symptoms)  
\_\_\_\_\_  
\_\_\_\_\_
6. Stop Date/when to stop giving the medication: \_\_\_\_\_

**Prescription Medication (a physician signature is required for prescription medication)**

I certify that I am the parent/guardian of the above named student. I request and authorize school personnel to dispense the above named prescription medication to my child in accordance with the prescription/doctors order.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Over-the-counter medication**

I certify that I am the parent/guardian of the above named student. I request and authorize school personnel to dispense the above named over-the-counter-medication to my child as directed above and in accordance with the package directions.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescription medication must be supplied in an original, labeled medication container. Most pharmacists will supply you with an extra, labeled medication container upon request. Over-the-counter medication must be supplied in the original container as purchased from the store.**