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

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:_____

If AM does is Missed at home dose can be given at school with notification from Parent _____Yes   _____No

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

_____   _____
Name of Licensed Prescriber & Title (please print name)   **Prescriber's Signature**
_____
Address   City   Phone No.   Date

C. SELF MEDICATION RELEASE FORM

** 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 P. E. locker.

_____(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.

☐ ** I Attest that this student had demonstrated to me that they can self-administer the medications listed safely and effectively and may carry and use this medication independently at school/school sponsored activities with no supervision by school staff.

_____   _____
Physician's Signature   Parent's Signature