

REQUEST TO ADMINISTER MEDICATION

I request that designated Lumberton ISD personnel administer the medication listed below to my child according to the physician/prescribing healthcare provider instructions. I agree to provide any and all medication in compliance with the included Medication Procedures.

Student Picture
(Campus will
provide)

Student ID: _____

PHYSICIAN/PRESCRIBING HEALTHCARE PROVIDER AUTHORIZATION

Name of Student: _____ DOB: _____ Grade: _____

Condition for which the medication is administered: _____

Name of medication, dose, and method administered: _____

Time or indication for administration: _____ Medication expiration date: _____

Side effects to be noted/reported: _____

Other recommendations: _____

Duration (dates) of administration: From _____ To _____ (Limit of one school year)

Physician Signature

Print Name

Phone

Date

PARENT/GUARDIAN AUTHORIZATION

By signing below, I acknowledge that:

1. I give permission for the designated Lumberton ISD personnel to administer this medication in accordance with the physician's instructions above.
2. I have read and understand the Lumberton ISD Medication Procedures.
3. I give permission for the school to contact the above health care provider about the administration of this medication.
4. I understand that the School District, the Board and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Parent/Guardian Name (Print)

Parent/Guardian Signature

Date