LAKEWOOD PUBLIC SCHOOLS

MEDICATION PERMISSION

School Year_____
Grade_____
ID#_____

Dear Parent/Guardian:

We attempt to discourage administration of medication in the schools. However, if your health care provider decides it is necessary for your child to receive a medication during the school day, his/her approval and specific directions must be provided to the school

Medication must be given to the nurse in the original prescription bottle by the parent/guardian.

Name of Student_____

Address_____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of order_____ Name of drug_____

Dose to be given_____

Time and circumstance of administration at school_____

_____

Can a reaction be expected? _____Yes _____No

If yes, please describe_____

_____

Have the potential side effects been explained to the parents by the health care provider?
_____Yes _____No

Health Care Provider Stamp _____ _____
Signature Date

I, the parent/guardian of _____ (student's name) am aware of the possible side effects of the medication prescribed by my health care provider.

I hereby give permission for the School Nurse to administer the medication to my child during school hours.

Parent/Guardian Signature_____ Date_____