MEDICATION AUTHORIZATION

PART I — TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request LCA school personnel to administer medication as directed by this authorization. I agree to release, indemnify, and hold harmless LCA school personnel, or agents from lawsuits, claim expense, demand or action, etc., against them for helping this student use medication, provided LCA school personnel comply with the Licensed Healthcare Provider (LHCP) or parent/guardian orders set forth in accordance with the provisions of Part II below.

Medication ☐ Renewal ☐ New (If new, the first dose must be given at home to assure that the student does not have a negative reaction.)

First dose given: Date: _____ Time: _____

Student Name:	D.O.B.	
Allergies	School: Legacy Christian Academy	School Year:

_____ _____ _____

Parent's/Guardian's Signature **Daytime Telephone** **Date**

PART II — TO BE COMPLETED BY PARENT/GUARDIAN FOR OCCASIONAL OVER THE COUNTER (OTC) MEDICATION, LICENSED HEALTH CARE PROVIDER (LHCP) MUST COMPLETE AND SIGN FOR ALL OTHER MEDICATIONS AND OTC'S ADMINISTERED FOR 4 OR MORE DAYS.

The school discourages the use of medication by students in school during the school day. Any necessary medication that possibly can be taken before or after school should be so prescribed. Injectable medications are not administered in schools except in specific situations with appropriate forms that comply with LHCP orders and are signed by parent/guardian. School personnel will, when it is absolutely necessary, administer medication, during the school day and while participating in outdoor education programs and school crisis situations.

DIAGNOSIS:	SIGNS / SYMPTOMS
MEDICATION:	ROUTE
DOSAGE TO BE GIVEN AT SCHOOL:	TIMES OR INTERVAL TO BE GIVEN

EFFECTIVE DATE: If student is taking more than one medication at LCA, list sequence in which they should be taken.
Start: End:

COMMON SIDE EFFECTS:

_____ _____ _____ _____

Licensed Health Care Provider's Name **Licensed Health Care Provider's Signature** **Date** **Phone**

_____ _____ _____ _____

Parent's/Guardian's Name **Parent's /Guardian's Signature** **Date** **Phone**

PART III — TO BE COMPLETED BY LCA SCHOOL PERSONNEL

Check ✓ the appropriate boxes:

☐ Parts I and II above are completed including signatures.
(It is acceptable if all items in Part II are written on the LHCP stationary or prescription pad.)

☐ Medication is appropriately labeled.

Date by which any unused medication is to be collected by the parent/guardian.
(Within one week after expiration of the physician order or on the last day of school.)

_____ _____ _____

LCA Personnel's Name **LCA Personnel's Signature** **Date**