MEDICATION ADMINISTRATION FORM

Student: ____ Grade: ______ DOB: ____________________

Address: ____

Name of Guardian(s): ____

Home Phone: _________________________ Cell Phone: _________________________ Work Phone: _______________________

Please list any allergies and/or medical conditions: ____

Height: ________ Weight: ________ Gender: ________ Emergency Contact: ____

Relation to student: ____________________________________ Emergency Contact Phone: _____________________________

Name of preferred hospital (in event of a medical emergency): ____

Name of Physician: ____ Physician's Phone: ___________________________________

Medication: ______________________________________

Dosage/Frequency: _______________________________

Time of administration: ____________________________

Special Instructions: ________________________________

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Medication: ______________________________________

Dosage/Frequency: _______________________________

Time of Administration: ____________________________

Special Instructions: ________________________________

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Medication: ______________________________________

Dosage/Frequency: _______________________________

Time of administration: ____________________________

Special Instructions: ________________________________

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Medication: ______________________________________

Dosage/Frequency: _______________________________

Time of Administration: ____________________________

Special Instructions: ________________________________

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I hereby request that my child be administered his/her prescribed medication(s) at school by school personnel. I understand that the medication will be administered in accordance with the LHSA board policy and the instructions of my above-named physician. I will notify the school of any changes and/or discontinuation of this medicine.

Parent/Guardian Signature: ____ Date: __________________

Physician Signature: ____ Date:____________________

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Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary prescribed medication to students for limited periods of time. NO hypodermic injections will be given. All medications must be in the original container, clearly labeled, and indicating the following information: the student's name, dosage, doctor's name, date issued, and the time it should be administered.

I do hereby request and authorize that the prescribed medication listed on the previous page be given to my son or daughter as indicated by the prescribing physician.

Parent/Legal Guardian Signature: ____ Date: __________________

Date	Time of Administration	Administered By	Medication/Dosage	Reason for Administration