AUTHORIZATION TO ADMINISTER MEDICATION BY SCHOOL PERSONNEL
Lake Holcombe School District

PART I: TO BE COMPLETED BY THE PARENT OR GUARDIAN

I HEREBY GIVE MY PERMISSION FOR SCHOOL PERSONNEL TO ADMINISTER MEDICATION AS DESCRIBED BELOW TO _____ *(student).*
I AGREE TO HOLD THE SCHOOL DISTRICT OF LAKE HOLCOMBE AND ITS EMPLOYEES WHO MAY ADMINISTER THE MEDICATION HARMLESS IN ANY AND ALL CLAIMS ARISING FROM THE SAID ADMINISTRATION OF THIS MEDICATION AT SCHOOL.

_____ _____
PARENT OR GUARDIAN SIGNATURE *DATE*

PART II: TO BE COMPLETED BY THE PARENT FOR AN OVER-THE-COUNTER MEDICATION

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE ADMINISTERED _____

DATE TO BEGIN MEDICATION _____

DATE TO END MEDICATION _____

MEDICATION MUST BE IN ITS ORIGINAL CONTAINER AND NOT BE BEYOND THE EXPIRATION DATE. OVER-THE-COUNTER MEDICATIONS MUST BE DISPENSED ACCORDING TO THE LABEL UNLESS OTHERWISE DIRECTED IN WRITING BY A PHYSICIAN.

NUTRITIONAL SUPPLEMENTS/DIETARY SUPPLEMENTS OR OTHER SUBSTANCES NOT REGULATED BY THE F.D.A. SHALL NOT BE ADMINISTERED BY SCHOOL PERSONNEL.

PART III: TO BE COMPLETED BY THE PHYSICIAN FOR PRESCRIPTION MEDICATION

PHYSICIAN'S NAME _____

PHONE _____

NAME OF MEDICATION _____

DOSAGE _____

TIME TO BE ADMINISTERED _____

DATE TO BEGIN MEDICATION _____

DATE TO END MEDICATION _____

POSSIBLE SIDE EFFECTS _____

_____ _____
PHYSICIAN'S SIGNATURE DATE

PRESCRIPTION MEDICATION MUST BE ACCOMPANIED BY A PHYSICIAN'S AUTHORIZATION AND ALSO PARENT/GUARDIAN WRITTEN CONSENT. PRESCRIPTION MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION CONTAINER WITH THE LABEL AFFIXED. STUDENT, DOCTOR, NAME OR DRUG, DOSAGE AND FREQUENCY MUST BE INDICATED. IF PRESCRIPTION OR DOSAGE CHANGES, A NEW PHYSICIAN'S AUTHORIZATION IS REQUIRED AND NEW PRESCRIPTION INFORMATION MUST BE ON THE CONTAINER.

TO ALSO BE FILLED OUT BY PHYSICIAN FOR INHALER USE

THE ABOVE STUDENT HAS BEEN INSTRUCTED IN THE PROPER WAY TO USE HIS/HER INHALED ASTHMA MEDICATION. IT IS MY PROFESSIONAL OPINION THAT HE/SHE SHOULD BE ALLOWED TO CARRY AND USE THIS INAHLED MEDICATION AS PRESCRIBED IF NEEDED PRIOR TO EXERCISE OR TO ALLEVIATE ASTHMA SYMPTOMS.

PHYSICIAN'S SIGNATURE _____