LAKEWAY
CHRISTIAN SCHOOLS

PHYSICIAN FORM FOR ADMINISTRATION OF MEDICATION AND SELF MEDICATION ADMINISTRATION

THIS FORM IS GOOD FOR UP TO ONE SCHOOL YEAR ONLY.

The following is to be completed by a health care provider (physician/nurse practitioner). No medication of any kind will be given to your child until this information is completed and returned to the school.

- All medication must be in a **pharmacy-labeled container. NOTE:** Over the counter medication prescribed by a physician/nurse practitioner must be brought to school in an unopened original container.
- If any changes in medication occur during the school year, a new form must be completed along with a new pharmacy/physician-labeled container and returned to the school.
- **Only one form for each medication is to be used.**
- Medication must be brought to school by a responsible adult. Please **do not send medication by children.**
- A parent signature is required before a student can be assisted with self medication.

TO BE COMPLETED BY PARENT:

Name of student _____ Date of Birth _____

School _____ Grade _____ Teacher _____

I hereby give consent for my child to be assisted in taking the medication described below at school. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed below. I will comply with the policy listed on the back of this form related to dispensing medication at school.

_____ _____ _____ _____
Parent / Guardian Signature Date Home Phone Work Phone

Mother's Cell Phone _____ Father's Cell Phone _____

_____
Emergency Contact (Name and Phone)

TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY:

Diagnosis for which medication is given _____

Name of medication _____ Dosage _____

Start Date _____ Stop Date _____

Form _____ Route _____ Special Handling Instructions: ☐ refrigeration ☐ keep out of sunlight ☐ other _____

If medication is to be be given daily, at what time? _____ A.M. _____ P.M.

Dates must be administered at school:

☐ Every day at school ☐ Episodic/Emergency events only ☐ Short term (list dates to be given) _____

If medication is to be given "when needed", describe symptoms student will exhibit. _____

_____ How soon can it be repeated? _____

Possible side effects and procedure to follow _____

_____

Physician's/Nurse Practitioner's Name **(Print)** _____

Physician's/Nurse Practioner's Signature _____ Date _____

Address _____ Zip Code _____

Phone _____ Fax _____

(School Staff Only) Completed form received on _____ ***By*** _____
Date Signature

Expiration Date of Medication (if available) _____

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