AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION
2023-2024

Instructions: Medications are encouraged to be administered at home by the parent/guardian whenever possible. If it is necessary for a scholar to receive medications at school, on field trips, or a school sponsored activity, this form must be completed by a healthcare provider and parent/guardian before medication can be given at school. Please fill out one (1) form for EACH required medication.

Scholars' Name: _____ **Date of Birth:** _____ **Grade:** _____

Parent Permission
I am requesting that my scholar, _____, receive prescription drugs or procedures at the time indicated and as designated by his/her healthcare provider.

- I will be responsible for bringing the prescription drugs to school in a labeled container from the pharmacist.
- I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies at the school. Failure to do this will result in an interruption of the physician's order or discontinuation of the school's administration of the medication/procedure for my scholar.
- I understand that, if my scholar refuses to take the prescribed medication(s) or allow the procedure(s), force will not be used by school personnel to make my child comply.

School personnel have permission to communicate with the prescribing medical provider regarding use, side effects, response, and contraindications of the medication(s) or the procedure results or frequency. I can rescind my permission at any time.

_____ _____ _____
Signature of Parent/Legal Guardian | Relationship | Date: (Mo./Day/Yr.)

Health Care Provider Authorization: I am prescribing the following medication and procedures for the above scholar to be administered or performed at school.

DAILY or **PRN**

Name of Daily Medication (Generic and Trade Name)	Dosage/ Frequency	Time(s) (AM/PM):	Start date	Stop date	Possible Adverse Side Effect or Contraindications:

The above orders shall be effective throughout the current school year, summer school and through September 30th of the following school year, unless the orders are discontinued, changed or withdrawn in writing by the parent/guardian before that time elapses.

_____ _____ _____
Medical Provider's Signature | Date (Mo./Day/Yr.) | Telephone/Fax Number

_____ _____
Printed Medical Provider's Name | Address

NON-PRESCRIPTION MEDICATION CONSENT FORM

This form must be completed and be on file in the main office in order for school personnel to administer any medications.

Scholars' Name: _____ **Date of Birth:** _____ **Grade:** _____

Name of medication: _____

Amount/Dosage: _____

Time(s) to be given: _____

Number of days to be given: _____

Reason for taking medication: _____

_____

- I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the above written instructions.
- I also hereby agree to give my permission to the school principal/designee to contact my child's physician.
- I further agree to hold the The Lincoln Academy and all employees harmless in any and all claims arising from the administration of this medication at school.
- I agree to notify the school in writing at the termination of this request or when any change in the above is necessary.

_____ _____

Signature of Parent/Legal Guardian **Date**

_____ _____

Parent/Legal Guardian (Please Print) Phone

REMINDER: All medication (Prescription/Non-Prescription) brought to school must have the following information printed on the container.

- Scholar's Full Name
- Name of Drug and Dosage
- Time to be Given
- Physician's Name and Phone Number