Medication Authorization Form

This form MUST accompany any medication brought to Lakehill

Prescription Medication

Student's Name _____ Date of Birth ___/___/___

Medication _____ Start Date ___/___/___ End Date ___/___/___

Dosage _____ Times to be given: _____ AM _____ PM

Last dosage given at _____AM/PM on date ___/___/___ Route (circle): mouth skin eye ear

Possible side effects _____

Special handling/storage instructions _____

___Refrigeration required: Yes No

Parent/Guardian Signature (required) _____

Physician or App Signature (required) _____

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Student's Name _____

Physician's Name _____ Phone Number _____

Medication _____ Start Date ___/___/___ End Date ___/___/___

Dosage _____ Times to be given: _____ AM _____ PM

Last dosage given at _____AM/PM on date ___/___/___ Route (circle): mouth skin eye ear

Possible side effects _____

Special handling/storage instructions _____

Refrigeration required: Yes No

Parent/Guardian Signature (required) _____

Physician or App Signature (required) _____

Unused Medication: Returned to parent: Yes No Discarded appropriately: Yes No

Administration Signature _____ Date ___/___/___

Contract for Self-Carried Medication

Student _____ Grade _____

Medication _____ Dose _____ Time_____

Medication is permitted in accordance with Lakehill policy. A student's physician must authorize self-carried/administered medication. This includes only emergency medications such as an epi-pen or inhaler. This does not include OTC medicines. The student name must appear on the medication container.

Responsibilities for carrying medication (to be completed by Parent/Guardian):

Yes No Medication Authorization Form complete and on-file in Health and Wellness Center

Yes No Student demonstrates correct use of medication

Yes No Student recognizes proper and prescribed timing for medication

Yes No Student agrees not to share medication with other students

Yes No Student agrees to keep medication in agreed upon location

Yes No Student agrees to report directly to Main Office if having the following symptoms after using the medication:

Please list _____

Yes No Student keeps a second, labeled container in the Health and Wellness Center

Physician Signature _____ Date _____

Student Signature _____ Date _____

I request that my child be allowed to carry his/her medication and be responsible for its proper storage and use. I will support my child to follow the above agreement and if he/she does not, I will be contacted and we will develop a new plan.

Parent/Guardian Signature _____ Date _____

Phone number _____