

# PHYSICIAN/ PARENT AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL



If your child needs to take medication during the school hours, Lynchburg City Schools will cooperate in giving the medication within the outlined regulations **only**:

1. According to LCS policy, this form **must be used** for **both prescription and over-the-counter medications**.
2. All blanks need to be filled in completely and correctly, detailing the name of the student, DOB, name of the medication, medication dose, route, time, side effects, reason/ diagnosis for giving the medication.
3. The **physician and the parent/guardian are required to sign & date this form**.
4. All medication **must be brought to the school by an adult**.
5. All prescription medication must be in the original bottle with appropriate label from the pharmacy that matches the written Physician's order below.
6. **Over-the-counter medication must be** in the original **unopened** bottle. We **will not accept** medication that is not in the original bottle.

Student Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Allergies \_\_\_\_\_

Name of medication/dose	How much medication to administer?	Route of medication?	Time to give medication?	Side effects of medication?	Reason/ diagnosis for medication
1.					
2.					
3.					
4.					

Anticipated number of days that medication needs to be given at school \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name Printed \_\_\_\_\_

Physician Office Name & Address \_\_\_\_\_

Physician Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

I hereby give permission for my child, \_\_\_\_\_, to take the above prescription(s) at school as ordered by the physician. I understand that it is my responsibility to furnish this medication according to LCS policy.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Printed Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Parent/Guardian Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_