PERMISSION TO ADMINISTER MEDICATION

Student: _____ D.O.B. _____

School: _____ Grade: _____

Date: _____

To Be Completed by Parents / Guardian

I hereby give permission for Lewis Central School to administer medication as prescribed below to my child _____. During the school hours, it is my understanding that a licensed nurse or medication certified staff will administer the prescribed medication according to physician's orders to my child. Your signature on this form will give us permission to contact this prescriber if we feel it is necessary.

_____
Parent's Signature

To Be Completed by Physician

Medication: _____

Recommended Dosage: _____

Time(s) to be administered: _____

_____

Possible side effects: _____

_____

_____
Prescriber's Signature

Thank You,

Nurse / Health Associate

Phone: _____ Fax: _____