Lisbon Central School Medication Form

This form must be filled out and be kept on file in the Nurse's Office.

Authorization to administer medications, either prescription or over-the-counter, during school hours.

- **TO BE COMPLETED BY PARENT**

Child's Name: _____ Date of Birth: _____

I request that my child be administered the medicine (s) described below by the School Nurse or her delegate, or is allowed to self-administer if it is authorized by myself, his physician, and the School Nurse.

Parent Name: _____ Date: _____

Parent Signature: _____

- **TO BE COMPLETED BY PHYSICIAN**

Diagnosis for which medication is to be given: _____

Name of Medication(s): _____

Dose: _____ Route: _____ Time: _____

Significant side effects, if any: _____

_____

_____

Is child authorized to self-medicate: _____

_____ _____ _____

Name of Health Care Provider Signature Date

2017-2018 School Year