LENOX PUBLIC SCHOOLS

This form is to be completed and signed by <u>both</u> a Parent/Guardian & Prescribing Physician

Authorization for Prescription Medication
To Be Taken During School Hours

SCHOOL (circle one): Morris Elementary LMMHS School Year: __________

STUDENT'S NAME:____
DATE OF BIRTH:______________

PHYSICIAN:____
ADDRESS____
TELEPHONE:____________________________FAX:_________________________

Diagnosis for which prescription medication is given _________________________

Name of medication: ____

Administration Route: __________________ Dosage: _____________________________

If medicine is to be given daily, what time should it be given? __________________

If medication is to be given "WHEN NEEDED", describe indications:
____

Length of time treatment indicated: ____

How soon medicine can be repeated: ____

List significant possible side effects: ____

Storage instructions: ____

FOR LMMHS STUDENTS ONLY:
**Special Exception: Inhalant medications for exercise-induced asthma, Epinephrine auto-injection, diabetic medications as needed for emergent health condition.*
**Do you consent for this student to carry and medicate him/herself? (Please circle below)*

Parent/Guardian Response *Yes* *No* *Physician Response:* *Yes* *No*

<u>Both signatures are required below:</u>

Physician signature: ____ Date ____________

Parent/Guardian signature: ______________________________________ Date ____________