

**LANCASTER CENTRAL SCHOOL DISTRICT  
PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL**

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**A. TO BE COMPLETED BY THE PARENT OR GUARDIAN:**

- I request that my child receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the **properly labeled, original container** from the pharmacy.
- I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

\_\_\_\_\_  
Please Print Name (Parent or Guardian)

\_\_\_\_\_  
Signature (Parent or Guardian)

\_\_\_\_\_  
Home Telephone No.

\_\_\_\_\_  
Work Telephone No.

\_\_\_\_\_  
Date

**B. TO BE COMPLETED BY THE LICENSED HEALTH CARE PRESCRIBER:**

- I request that my patient, as listed above, receive the following medication:

Medication: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Time: \_\_\_\_\_ Duration of Treatment: \_\_\_\_\_

Possible Side Effects and Adverse Reactions (if any): \_\_\_\_\_

Other Recommendations: \_\_\_\_\_

\_\_\_\_\_  
Name of Licensed Prescriber & Title (please print name)

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
Phone No.

\_\_\_\_\_  
Date

**\*\*NOTE: This section must be signed, in addition to the above, for those students who request permission to carry their own medication on campus or keep this medication in a P. E. locker.**

**SELF MEDICATION RELEASE FORM**

\_\_\_\_\_(child's name) has been instructed in the proper use of the medication listed above. We request that he/she be permitted to carry the medication on his/her person or to keep same in his/her locker or p.e. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Parent or Guardian Signature

I understand and agree that I am responsible for this medication that I will carry. I will not take more than the ordered dose of this medication and I will not share this medication with anyone else.

\_\_\_\_\_  
Student's Signature