LAKEVIEW ACADEMY AUTHORIZATION OF SCHOOL PERSONNEL TO ADMINISTER MEDICATIONS

Name of Student_____DOB_____

Address_____

Parent/Guardian_____Cell Phone_____

Work Phone_____Home Phone_____

Emergency Contact/Relation_____Phone_____

Name of licensed health care provider completing form (Please Print)

_____

Licensed Health Care Provider's Statement:

1. Name/type of medication_____
2. Dosage/amount to be given_____
3. Frequency/times to be administered_____
4. Duration (week, month, indefinite, etc.)_____
5. Anticipated reactions to medication (symptoms, side effects for under dose/overdose, etc.)

   _____

   _____

   _____

   _____

_____ _____

Signature of Licensed Health Care Provider Date

Parent/Guardian Request/Approval

I hereby request and give my permission for the above named student to receive the specified mediation as stated in the above instruction from the health care provider. I understand that the school administration will designate specific staff to administer medication, train staff assure proper identification and safekeeping of medication and maintain records of such administration of medication.

I further understand that school personnel who provide assistance (administration of specified medication so noted) or employer of such staff are not liable, civilly or criminally for any adverse reaction suffered by y child as a result of taking the medication so indicated and discontinuing the administration of the medication in keeping with the procedure outlined above.

I will personally deliver medication to the school and understand that a one-week supply is recommended.

_____ _____

Signature of Parent/Guardian Date