300 DIAMOND STREET, LEXINGTON, VIRGINIA 24450

Name of School: ___________________________________ School Year: ___________________

MEDICATION PERMISSION FORM - PRESCRIBED MEDICATION – CONSENT FOR ADMINISTRATION

I am the parent or guardian of _____________________________. I give my permission for him/her to take the following prescribed medication while in the Lexington City Public Schools. I understand that this includes permission for my child's teacher to administer this medication if the administration time falls during the hours of a field trip. I also give my permission for school personnel to obtain from and release to the primary physician any information pertaining to this medication. I hereby acknowledge that I have read and understood the School board Regulations relating to the taking of medications. I understand that the person at the school who will administer this medication or treatment may be inexperienced in this requested service and state, without reservation, that I shall not hold him/her or the Lexington City School board liable in any way for harm or injury that may be experienced by my child as a result of this service. **I understand that medication must be brought to school by parent or guardian.**

____ ______________________ _____________________

Signature of Parent or Guardian Daytime Phone Number Date

Student Name: ______________________________________ Grade: ____________ Birth date: _________________

Allergies: ____

FOR USE BY PHYSICIAN/HEALTH CARE PROVIDER ONLY:

Relevant Diagnosis____

Medication: ____

Direction for School Personnel:

Give this Medication: ___ Short Term ____ Every School Day ____ For Episodic/Emergency Events Only

Dosage (Amount): _____________________________ Route: ___Oral ___Inhaled ___Injected ________Other

Time(s) of Day: ________________________________ Form: ___Tablet ___Liquid _________Other

Reactions: - Serious reactions can occur if the medication is **<u>not</u>** given as prescribed: ___Yes ___No

If yes, describe: ____

- Serious reactions/adverse effects from this medication may occur: ___Yes ___No

If yes, describe: ____

Report to you ___Yes ___No

Special handling instructions:

___Refrigeration ___Keep out of sunlight ___Other: ____

Asthma/Diabetes <u>Only</u>

This student is both capable and responsible for self-administering this medication:

___No ___Yes, Supervised ___yes, Unsupervised

Physician Signature: ____ Date: ______________________

Physician Name (please print): _______________________________________ Phone #: ___________________

IT IS ENCOURAGED TO USE THIS FORM FOR NON-PRESCRIPTION MEDICATIONS

This form is applicable only to the medication prescribed above and only good for the current school year. A separate form is required for each medication. Additional copies of this form are available in your child's school office.