Lehman Catholic HIGH SCHOOL

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Student Name ..... Date of Birth .....

Physician's Name .....

PHYSICIAN - PLEASE COMPLETE:

The above-named student is under my care and should receive:

Name of Drug ..... Dose ..... Times .....

Reason for drug to be administered at school .....

Beginning date of this request ..... Expiration date of this request .....

Special instructions for administration .....

Side effects to watch for .....

....
Physician Signature | Phone | Date

Parent must indicate that the student is allowed to self-carry their emergency medication & supplies.

☐ I authorize and recommend self-medication by my child for the prescribed listed medication.

Medication .....

☐ I also affirm that my child has been instructed in the proper self-administration of the prescribed medication by their attending prescriber.

....
Parent / Guardian's Signature | Date

PARENT / GUARDIAN - PLEASE COMPLETE:
PARENT'S PERMISSION FOR THE ADMINISTRATION OF THE MEDICATION BY SCHOOL PERSONNEL.

I hereby request and give my permission to the principal or a designee (nurse, secretary, teacher, or another responsible person) to administer the above-named medication to my child by the above-named physician as prescribed.

....
Physician Signature | Phone | Date

Parents must send medication to the school in its original container.
Note: The parent / guardian of the child must assume responsibility for informing the principal of the school and the school nurse of any change in the child's health or any change in the prescribed medication. Any change to the above prescription (dosage or administration) will require the completion of a new form.

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School Official's Signature (Acknowledging Receipt) | Date

Revised 06/2021