Request for Medication to be Given During School Hours

To be Completed/Signed by Physician:

Name of Student: _____ School: Lincoln Charter School

Medication: _____ Dosage/Route: _____

(No injection will be given except in extreme emergency, such as allergy to bee stings)

Time(s) Medication is to be given at school: _____ am _____ pm

To be given from (date) _____ to (date) _____

Significant Information: (e.g., purpose of medication, side effects, any special instructions for giving at school, contraindications):

_____

Would it be acceptable to keep the medication in the school's main office? _____

(All medications are held under lock and key in Main Office's)

This medication will be furnished by parent/guardian within a container properly labeled by a pharmacist with identifying information, (e. g., name of student, medication dispensed, dosage prescribed, and the time it is to be given). Over-the-counter medications will be in the original container labeled with the student's full name.

Physician's Signature: _____ Date: _____

Group/Practice Name: _____ Phone #: _____ Fax # _____

Physician is to complete this box ONLY if student is to CARRY and SELF-MEDICATE with inhaler or epinephrine auto-injector.

I feel that it is medically necessary for the above named student should and is responsible enough to carry his/her own medication and self-medicate as prescribed. I have provided education to the student on indications for the use of the medication and methods of administration.

Physician's Signature: _____ Date: _____

Parent's Permission

I hereby give my permission for my student/child named above to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the LCS School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

Reviewed By School Personnel:

_____
Signature (who reviewed/received)

_____
Date (medication & form received)

_____
Signature of Parent/Guardian & Telephone Number

_____ _____
Expiration Date of Medication Date this form was complete

DENVER CAMPUS
7834 GALWAY LANE
DENVER, NC 28037

LINCOLNTON CAMPUS
133 EAGLE NEST ROAD
LINCOLNTON, NC 28092