Date:_____

Grade:_____

Lovejoy Independent School District

Medication Permission Form 2018-2019

Parent or Guardian must bring medication to the Nurse Office, please

STUDENT_____DOB:_____

Parent_____Phone: _____

Medication Allergies: ☐ None Yes: ☐ to:_____

Name of Medicine:_____ _____

What is medication needed for?_____

Dosage:_____Route:_____

When to give:

_____ Every _____hours as needed

_____ Daily at_____

_____ One time dose only

_____ Temporary on dates listed below:

_____, _____, _____, _____, _____

PARENT/ LEGAL GUARDIAN SIGNATURE:

_____

I REQUEST THE ABOVE MEDICATION BE ADMINISTERED TO MY CHILD.

I authorize, as needed, the sharing of information regarding my child's health between the school nurse and the prescribing health care provider.

Date:_____

Controlled medication count sheet completed____

_____ IS

LOVEJOY ISD DOES NOT SUPPLY MEDICATION

NO PILLS IN BAGGIES / MEDICINE MUST BE IN ITS ORIGINAL CONTAINER (BOX OR BOTTLE)

NO EXPIRED MEDICATIONS / (PLEASE WRITE EXPIRATION DATE:_____)

SAMPLE MEDICINES ACCEPTED ONLY WITH WRITTEN DIRECTIONS FROM PHYSICIAN

ALL PRESCRIPTION MEDICATIONS MUST HAVE LABEL ON BOX/MEDICATION

ALL MEDICINE NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DISCARDED

A Physician's written request may be required if an over-the-counter medication is to be given more than 3 times per school week, dosage other than FDA package instructions, or more than a total of 10 prn doses have been administered.
A Physician signature is required to administer prescription medications during the school day for more than 10 consecutive doses and if there is a change in prescription

Condition for which medication is required: _____ Date:_____

Medication: _____Strength: _____ Dosage: _____Time:_____

Physician Name: (PRINT)_____ Physician Signature_____

Phone:_____Fax:_____Special Instructions_____

_____