Form for Self-Administered Medicine

Lanesville Community School

(Fax # 812-952-3762)

Name of student____________________Date of Birth__________Grade_____

Allergies____Teacher_____________

TO BE COMPLETED BY THE PHYSICIAN:

Medication to be given: ____

Dosage to be given: ____

Time of Day to be given: ____

Condition being given for: ____

Start Date: ______________ Stop Date: [ ] End of School Year [ ] Other __________

Special Instructions:

[ ] This medication is to be self-administered by the student. He/she has been instructed in how to self-administer the medication.

[ ] Please observe for the following adverse reactions: ______________________

____

[ ] Other ____

____

Physician's Signature: ________________________________ Date: _________
Physician's Printed Name: ________________________________
Physician's Phone Number: ____________________
Physician's Address/City/State/Zip: ________________________________

TO BE COMPLETED BY THE PARENT:

I request, authorize, and give permission for the above named student to receive this medication during the school day as indicated. I authorize school personnel to exchange information regarding this medication with the health care provider listed above and/or the dispensing pharmacy.

Parent/Legal Guardian Signature: ____________________________ Date: ________

A form must be completed for each medication.