AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT AND PHYSICIAN)

PLEASE PRINT SCHOOL YEAR: ________

STUDENT'S NAME: ______________________________ BIRTH DATE: ______________

LEGAL GUARDIAN: ____________________________ DAYTIME PHONE: _________________

NAME OF MEDICATION: _____________________________________

REASON FOR TAKING MEDICATION AT SCHOOL (PLEASE BE SPECIFIC): ____

AMOUNT OF MEDICATION TO BE TAKEN: _________________ TIME MEDICATION IS TO BE TAKEN: __________________

DATE TO **START** MEDICATION: ________________ DATE TO **STOP** MEDICATION: ______________

EXPIRATION OF MEDICATION: _________________ POSSIBLE SIDE EFFECTS: _____________________________________
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Parent's please read carefully:

Working closely with our Physician, we have decided to allow my child to self-administer and self-monitor the above medication while at school. My child has been trained by our physician and has demonstrated competency in this procedure. My child must be allowed to possess this medication at school, in transit to and from school or school-sponsored activities, and during, before or after- school activities on school property. I realize that Legacy Charter School cannot be held responsible for any adverse outcome of this action. I am responsible for replacing expired medication before the expiration date. I will provide the medication in the original container, clearly labeled with the child's name. I will notify the school immediately if the medication is discontinued or the dosage has changed. Permission is granted to the principle and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor for adverse reactions. I give the school nurse my permission to contact the physician's office to request medical information concerning my child.

Legal Guardian's Signature: _______________________________________ Date: ___________________

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Physician please read carefully:

I agree that this student must be allowed to have the above named medication on his/her person during school hours, in transit to and from school or school-sponsored activities, before and after-school activities on school property, and any school sponsored activity. This child has demonstrated competency in self-monitoring and self-administration of this medication. The parent is aware that they cannot hold LCS responsible for any adverse outcome of this action.

Physician Signature: ____ Date: _________________

Office phone number: ________________________________ School Designee: __________________________