Lutheran Central School
Prescription Medication Permission Form

Prescription Medication Permission Form

Name of Student_____ Grade_____
Medication_____ Dosage_____ Time (s) _____
Pharmacy and Prescription number_____ Expiration Date_____
Prescribing Provider _____ Phone number_____
Duration

- ❏ Start Date _____ End Date _____
- ❏ I would like my requests indicated above to remain in effect this entire school year

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I authorize school personnel to administer the above medication to my child and agree that I will not hold liable any member of the school staff or any individual of official capacity who is directed by myself and the school nurse to assist my child in taking the above indicated medication(s). Medication dosing and administration will be administered only as the prescription label indicates. The label must be unaltered. I understand that the school nursing staff reserves the right to request further clarification from the prescribing provider. I understand that this consent shall be valid for no longer than the current school year **If there is any change in the medication administration, an updated Medication Authorization Permission Form must be filed. In the event medication is to be terminated prior to the date on the prescription, or as indicated on this form, a written withdrawal of consent of the parent is required.** The written consent of the parent and the written order of the physician shall be kept on file in the health office. I understand that it is my responsibility to provide the school with the above medication (s) for my child. Any unused medication will be released to the student's parent or guardian, an individual who is at least eighteen years of age and designated in writing by the student's parent or guardian to receive the medication, or the student as indicated below. I understand that any unused medication which is unclaimed by the parent or student within two weeks of the last dose will be destroyed by the corporation.

<u>Permission for transportation of medication(s):</u>

- ❏ I authorize my student to transport medication to and from school
- ❏ I will pick up any unused medication
- ❏ I authorize my child's unused medication to be released to:

  _____
  (I verify that the above named individual is at least 18 years of age)

Parent/GuardianSignature_____Date_____