Date:_____

Grade:_____

Lovejoy Independent School District

Medication Permission Form 2016-2017

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

Contact your school nurse for concerns or questions.

A Physician signature is required to administer prescription medications during the school day for more than 10 consecutive doses and if there is a dosage change

STUDENT_____**DOB:**_____

PARENT / GUARDIAN_____**Phone**_____

Email address_____

Medication Allergies: ☐ **None** **Yes:** ☐ **to:**_____

What is the medicine needed for?_____

Name of Medicine:_____ **_Dosage on Container**_____

How much to give_____Pills(mg) _____Drops (mg)
_____Tsp _____cc/ml
_____TBSP_____Puffs

How to give: _____ Oral (swallow or chew)
_____ Inhalation
_____ Topical (apply to eyes, skin, etc.)
_____ Other_____

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

INHALERS MUST HAVE PRESCRIPTION LABEL ON INHALER OR BOX

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**_____

_____