LEMAN ACADEMY
of EXCELLENCE

Health Office

ADMINISTERING PRESCRIPTION MEDICATION AT SCHOOL

Note: This form is valid for the 2024-2025 School Year.

Scholar Full Name: _____ Birthdate: _____

Allergies: _____ Weight: _____ lbs

Medication must be delivered to school in the original container with the label intact and includes the scholar's name. The medication is to be given in the following manner:

Name of Medication:

Strength of Medication: _____

Amount to be given: _____

Time of Administration at School:

Route of Administration (by mouth, etc.): _____

Instructions and/or Comments: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

Pharmacy and Prescription Number: _____ Expiration Date: _____

☐ **Refer to Pharmacy Prepared Label on medication vial for Healthcare Provider signature, or see below:**

_____ _____
Healthcare Provider Name (Print) Phone

_____ _____
Healthcare Provider Signature Date

Per A.R.S. 15-344 I hereby request and give my consent for the school health coordinator or other school personnel designated by the Principal to administer the medication indicated above. I give authorized school personnel permission to discuss my child's medication with the above named Provider. I understand it is my responsibility to provide the medication, and that it be presented to the school by an adult. I understand that it is my responsibility to notify the school immediately if there are any changes in medication, and that a new form must be completed. The school shall not be held responsible for missed or refused doses or side effects caused by the medication. In return for the school's assistance in administering the medication, I hereby waive any claim for injury against the school, or it's employees, arising from the medication administration. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

_____ _____
Parent/Guardian Name (Print) Date

_____
Parent/Guardian Signature