LEMAN ACADEMY
of EXCELLENCE

Health Office

PERMISSION FORM
ADMINISTERING PRESCRIPTION MEDICATION AT SCHOOL

School Year: _____*(Form is valid for one school year only)*

Scholar Full Name: _____ Birthdate: _____

Allergies: _____ Weight: _____ lbs

Medication must be delivered 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: _____

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 Health Care Provider signature, or see below:**

_____ _____
Health Care Provider Name (Print) Phone

_____ _____
Health Care Provider Signature Date

Per A.R.S. 344 I hereby request and give my consent for school personnel designated by the Principal to administer the medication indicated above. 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.

_____ _____
Parent/Guardian Name (Print) Date

_____
Parent/Guardian Signature