LINCOLN-WAY HIGH SCHOOL DISTRICT 210 – MEDICATION AUTHORIZATION FORM

Please return this form to the school nurse

STUDENT NAME: _____

STUDENT ID#_____GRADE_____DATE OF BIRTH _____

Physician's orders: ***(To be filled out by the attending Doctor -please print)***

Medication #1. _____ Dosage _____ Route _____

Time to be given _____Reason for prescribing medication_____

Possible side effects of medication _____

Medication #2. _____ Dosage _____ Route _____

Time to be given _____Reason for prescribing medication_____

Possible side effects of medication _____

Medication #3. _____ Dosage _____ Route _____

Time to be given _____Reason for prescribing medication_____

Possible side effects of medication _____

Medication #4. _____ Dosage _____ Route _____

Time to be given _____Reason for prescribing medication_____

Possible side effects of medication _____

Physician's signature _____ Date _____

Address _____ Phone Number _____

Parent Authorization: ***(To be completed by parent/guardian)***

I hereby grant my permission for Lincoln-Way High School to administer to_____ the above named medication as prescribed by the above physician. I agree to provide medication in a properly labeled bottle from the pharmacy. The medication will be kept in the nurse's office, and the student will report to the nurse's office to receive the prescribed medication.

Please check this box if this medication was prescribed for Band camp or a Lincoln-Way District 210 outside activity ☐

Parent/Guardian signature: _____

Address _____

Home phone no. _____Work phone no. _____Date _____

Nurse: ***(To be completed by school nurse)***

Medication #1. _____ Dosage _____Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Medication #2. _____ Dosage _____Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Medication #3. _____ Dosage _____Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Medication #4. _____ Dosage _____Route _____ Administration time _____

Prescription # _____ Pharmacy Name _____ Physician Name _____

Special instructions for dispensing #1 _____ #2 _____

#3 _____ #4 _____

Other Medication needed _____

School Nurse signature _____ Date _____