

Lakeland Christian School Authorization for Medication

The following section is to be completed and signed by the **PARENT**:

A new authorization must be completed at the beginning of each school year or anytime a dosage is changed.

Child's Name: _____	Sex: _____	Grade: _____	Date of Birth: _____
Physician's Name: _____		Telephone: (____) _____	
Physician's Address: _____		Fax: (____) _____	
I hereby authorize the above named physician and Lakeland Christian School staff to reciprocally release verbal, written or faxed protected health information (PHI) regarding the above named child for the purpose of giving necessary medication and/or treatment while at school. I understand PHI is confidential and is protected by the Health Insurance Portability and Accountability Act (HIPAA).			
I request that my child be administered and/or assisted in taking the medicine(s) described below at school by authorized persons as permitted by me and my physician (see below).			
Date: _____	Parent/Guardian Signature: _____		
Home Phone: (____) _____	Emergency Phone: (____) _____		

The following section is to be completed by the **PHYSICIAN**

Diagnosis for which medication is given: _____
Name of Medication: _____
Form: _____
Dose: _____
If is to be given at school, at what time? _____
If medicine is to be given "AS NEEDED", describe indications: _____

How soon can it be repeated? _____
List significant side effects: _____
Length of time this treatment is recommended: _____
Other information: _____

Date: _____ Physician's/Mid-level Practitioner's signature: _____



Place Office Stamp Here