Authorization for Medication /Treatment

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. All medications and/or treatment, equipment or supplies must be provided by the parent.

Child's Name _____ _____ _____ _____
Last First Sex Grade Date of Birth

_____ _____
Physician's Name Address Emergency Phone

I hereby authorize the above named physician and Lakeland Christian School (LCS) staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above named child for the purpose of giving necessary medication or treatment while at school. I understand that LCS protects and secures the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed, or electronic.

I request that my child be assisted in taking the medication or treatment 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:
(***ONLY ONE*** *medication or treatment per form*)

Diagnosis for which medication or treatment is given:

Name of medication or treatment: _____

Form: _____

Dose: _____

If medication or treatment is to be given at school, at what time? _____

If medication or treatment is to be given "When needed", describe indications: _____

How soon can it be repeated? _____

List significant side effects: _____

Length of time medication/treatment is recommended: _____

Other information:

_____
_____

_____ _____
Date Physician's/Mid-Level Practitioner's Signature

Place Office Stamp Here

Please fax the completed form to the Lakeland Christian School nurse at 863-682-5637