A TRADITION OF EXCELLENCE FOR ALL

LCS

LYNCHBURG CITY SCHOOLS

PHYSICIAN/ PARENT AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

Dear Parent or Guardian:

If your child needs to take medication during the school hours, Lynchburg City Schools will cooperate in giving the medication within the outlined regulations ONLY:

1. According to LCS policy, this form **MUST BE USED** for **BOTH PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS.**
2. All blanks need to be filled in completely and correctly, detailing the name of the student, DOB, name of the medication, medication dose, route, time, side effects, reason/ diagnosis for giving the medication.
3. The **PHYSICIAN AND THE PARENT/GUARDIAN ARE REQUIRED TO SIGN & DATE THIS FORM.**
4. All medication **MUST BE BROUGHT TO THE SCHOOL BY AN ADULT.**
5. All prescription medication must be in the original bottle with appropriate label from the pharmacy that matches the written Physician's order below.
6. **OVER-THE-COUNTER MEDICATION MUST BE** in the original **UNOPENED** bottle. We WILL NOT ACCEPT medication that is not in the original bottle.

Name of Student_____**DOB:**_____

School_____**Grade**_____**Teacher**_____

Allergies_____

Name of Medication/ Dose	How much medication to administer?	Route of medication?	Time to give medication?	Side effects of medication?	Reason/ diagnosis for medication
1.					
2.					
3.					
4.					

Anticipated number of days that medication needs to be given at school_____

Signature of Physician_____ **Date**_____

Printed Name of Physician_____

Physician's Office Name & Address_____

Physician's Office Phone_____FAX_____

I hereby give permission for my child, _____, to take the above prescription(s) at school as ordered by the physician. I understand that it is my responsibility to furnish this medication according to LCS policy.

Signature of Parent/ Guardian_____**Date** _____

Printed Name of Parent/ Guardian_____ Relationship to student_____

Parent/Guardian Home # _____Cell #_____