Lakeside Charter Academy Medication Authorization

Student Name: _____ Birthdate: _____ Grade: ____

In order to help protect your child's health, your consent **and** written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve Lakeside Charter Academy's Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

_____ _____ _____

Signature Date Contact Numbers

___ This medication is to be used for emergencies only. Please allow this student to self-administer this medication.

*** Both sides of this form are required for emergency self-carry medications. Student must be in the 6th grade or older to carry medication. ***

To be filled out by physician (health care provider with prescriptive authority):

Medication: _____ **Strength/Dose:** _____

Medical Diagnosis: _____

How often and/or at what time (hour): _____

Purpose of Medication: _____

Relationship to meals, if applicable: _____

Expected side effects or adverse reactions: _____

Other information: _____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal or front office staff as well as the parents/guardians if there are any problems.

_____ _____ _____ _____

Signature of Health Care Provider Date Telephone Fax

_____ _____

Please print practitioner's last name Practice name/address

FOR SCHOOL USE ONLY:

Date Received: _____ Reviewed: _____

Location of Medicine: ___ on student, emergency medication only ___ Front Office ____ Classroom

Student's Name: _____ Birthdate: _____

Medication: _____ for _____

Eligibility: Only students with asthma, diabetes, and/or severe allergies who may require rescue medications (i.e. inhaler, glucagon, insulin, epipen, Benadryl).

Healthcare Provider: This student is capable of and has been instructed on how to self-carry and, if applicable, administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please all him/her to self-carry it during school hours or activities. In the event of an emergency, this student may need assistance by a school staff member in the administration of this medication.

Healthcare Provider Signature: _____ Date: _____

Parent/Guardian: I give consent to Lakeside Charter Academy to allow my child to self-carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I will provide backup medication to be kept at school. I absolve the Lakeside Charter Academy Board and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

Parent Signature: _____ Date: _____

Student: I am capable of carrying this medicine as recommended and accept responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when medication is used.

Student Signature: _____ Date: _____

School Representative: I have reviewed this request and the medication is eligible for self-carry.

Representative Signature: _____ Date: _____

FOR SCHOOL USE ONLY:

Date Received: _____ Reviewed: _____

Location of Medicine: ___ on student, emergency medication only ___ Front Office ____ Classroom