Lockport City School District
Parent and Physician Authorization for Administration of Medication

A. To be completed by the Parent or Guardian:

I request that my child: _____DOB _____ receive the medication as prescribed below by our physician.

*Medications must be in their **original container**. This includes over the counter preparations.
*Medication and refills must be **delivered directly** to the school nurse by the parent/guardian.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by Physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: □ Entire school year Start Date: _____Stop Date: _____

Possible Side Effects and Adverse Reactions (if any) _____

☐ I deem this child to be **self directed: able to carry and administer medication independently, including during field trips or school sponsored events. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.**

(*School nurse will also assess student's ability to for self-directed medication administration).*

Physician's Signature _____ Date:_____

Address: _____ Phone:_____
12/08 BS:bas