Lockport City School District

Parent and Physician Authorization for Medication Administration

During School Sponsored Events

A) To be completed by the parent or guardian:

I request that my child ____________________________ DOB_______________ receive the following medications during this school sponsored event as prescribed by my physician.

*Students may not carry or take medications that are not ordered by the physician.

*Medications will be supplied in the original container, this includes over the counter medication.

*Medication must be delivered to the event coordinator/school staff in charge prior to the event.

*Medications must be picked up right away following the completion of the event.

☐ My son/daughter has my permission to attend this school sponsored event. I understand that he/she will be subject to all rules, regulation and supervision of the chaperones. I authorize any necessary medical treatment for this student while participating in this school sponsored event. I guarantee payment for services rendered.

PARENT/GUARDIAN

SIGNATURE: __________________________________ DATE: __________________________

TELEPHONE: Home: ______________________ Cell: ______________________Date: ____________________

B) To be completed by the physician:

I request that my patient, as listed below, receive the following medication during this school sponsored event:

NAME OF STUDENT: ____ DOB: ____________________

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINSTRATION	SELF ADMINSTER

☐ I deem this child to be self-directed and is able to carry and administer the medications listed above independently. He/she has been instructed in and understands the purpose and appropriate method and frequency of use.

PHYSICIAN'S SIGNATURE: ____________________________________ DATE: ______________________

OFFICE STAMP: