Lockport City School District

Parent and Physician Authorization for Medication Administration

During School and Field Trips during the School Day

A) To be completed by the parent or guardian:

I request that my child _____ DOB_____ receive the following medications during the school day, or on a field trip, as prescribed by my 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.

☐ My son/daughter has my permission to attend field trips. 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 field trips. I guarantee payment for services rendered.

PARENT/GUARDIAN

SIGNATURE: _____ DATE: _____

TELEPHONE: Cell: _____ Home: _____ Work: _____

B) To be completed by the 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 ADMINSTRATION

Duration of Treatment: ☐ Entire School year Start Date: _____ Stop Date: _____

Possible Side Effects/Adverse Reactions (if any): _____

☐ 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: _____

ADDRESS: _____ PHONE:_____

OFFICE STAMP: