Lewiston-Porter Central School District

Aiming Higher

AUTHORIZATION FOR MEDICATION ADMINISTRATION IN SCHOOL

Student's Name _____ Date of Birth _____

I request that my child receive the medication as prescribed below by our health care practitioner. I will provide the medication in the properly labeled original container from the pharmacy or manufacturer. I understand that students are not allowed to transport prescription or over the counter medications and an adult will deliver these to the school nurse.

Parent/Guardian's Signature _____ Date _____

Home Phone/Cell # _____ Work # _____

My patient, as listed above, should receive the following medication(s).

Medication	Dose	Time	Route

Possible side effects may include: _____

*** For inhalers and epi-pens only***

I have determined that this student is self-directed and due to the severity of the health care issue, this student should be allowed to carry and self-administer his/her own medication. This student has been educated and has demonstrated sufficient knowledge and maturity to carry and use this medication safely.
Health Care Provider's signature_____

Health Care Provider's Signature _____ Date _____

Health Care Provider's Phone # _____Provider's stamp