Lanesville Community School Medication Form

(fax # 812-952-3762)

Name of student _____ Date of birth _____ Grade ____

Allergies _____ Teacher: _____

Non Prescription Medication

To be completed by parent

Name of Medication: _____

How often or time to give: _____ How many to give: _____

Start date: _____ Stop date: _____ OR End of school year

Condition being given for _____

I, _____, give my permission for my child to receive the above medication as directed.

_____ _____

Date Parent or Legal Guardian Signature

Prescription Medication

To be completed by Healthcare Provider

Name of medication: _____

Specific times to be given: _____ Specific doses: _____

Start date: _____ Stop date: _____ OR End of school year

Condition being given for _____

_____ _____

Printed name of Healthcare Provider Signature of Healthcare Provider

_____

Date

To be completed by parent/guardian

I request, authorize, and give permission for the above named student to receive this medication during the school day as indicated. I authorize school personnel to exchange information regarding this medication with the health care provider listed above and/or the dispensing pharmacy.

Parent/Legal Guardian signature: _____ Date: _____

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For All Students

I authorize the school personnel to allow my child _____ to transport home any unused portion of the above medication. (*Please indicate date below)*

End of the school year *or* Other date _____

Parent or guardian signature _____ Date _____