Lebanon Christian School

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I have no greater joy than to hear that my children are walking in the truth
-3 John 4

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION

It is necessary that _____ have medication during school hours.

Medication Dosage Time Duration

_____
_____
_____

Diagnosis requiring medication:_____

If medication is as needed, how soon can it be repeated:_____

Possible reactions to be reported to physician:

_____
_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma or other emergency:

_____
_____
_____

Special instructions for administration / storage of drug:

_____

For an EMERGENCY medication (inhaler, epi-pen), do you wish for it to be:
_____ Carried and monitored by student
_____ Stored in the office and given by trained school personnel

PHYSICIAN'S SIGNATURE:_____DATE:_____

ADDRESS:_____PHONE:_____

PARENT PERMISSION AND RELEASE

Child's Name:_____Sex:_____Date of Birth:_____

I give permission for the medication ordered by the physician to be given at school and further agree to:

1. Deliver the medication to school.
2. Notify the school if I change physicians.
3. Notify the school if the medication or dosage is changed or eliminated.

Parent's Signature:_____Phone:_____Date:_____

School Nurse Approval:_____