

LYNDEN CHRISTIAN SCHOOL

PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student _____

Grade _____ Teacher _____

Names of Medication (please indicate generic as well as brand name)

Dosage _____ Specific time(s) to be given _____

Do you want noon medication given on half days? __ Yes __ No

Permission to carry inhalers __ Yes __ No

Other instructions and special concerns _____

I certify that I am the parent, legal guardian, or other person in the legal control of the above identified student. I request and authorize the school to administer the medication prescribed.

I understand the medication must be furnished in an original container from the pharmacy with the student's name, the name of the medication and the amount to be given. Non-prescriptive medication must be furnished in the original container from the manufacturer. All medication must be in a form ready to be administered and must not require any preparation by school staff.

It is the parent's responsibility to deliver and maintain an adequate supply of the medication at the school.
*The student may not deliver the medicine.

I understand that my signature indicates that the school accepts no liability for untoward reactions when the medication is administered in accordance with physician's directions. In the event that the student does not report at the appointed time to the school employee whom regularly administer the medications, I understand the dosage may be delayed or missed. If there is any medication left at the end of school year, it will be destroyed if I do not pick it up within 5 working days after school is out.

As a general rule the school will not administer prescribed medication during field trips. I understand that in those instances where medication must be administered, I will make arrangements atleast 24 hours prior to the field trip with a school employee who will be accompanying the student on the trip.

Parent/Guardian
Signature _____ Date _____

Telephone
Number _____
home work