LYNDEN CHRISTIAN SCHOOL

PHYSICIANS AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

Student______________________________ Birthdate______________________

Medication will be given to a student at school only when absolutely necessary. The parent and legal prescriber are urged to design a schedule for giving medication outside of school hours. It this is not possible, designated school employees will dispense the medication.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the directions of the student's physician.

This portion is to be completed by the student's physician or dentist:

Name of Medication__________________________ Generic Name_______________

Dosage_________________________ Time(s) of Dosage________________________

Reason Medication must be Given____

Anticipated Action of Medication____

Inhalers____
Indicate if student is to carry on his/her person

Length of Prescriptive Period: From___________________ To____________________

Please fill out the following if medication is to be given for more than 15 days:

Possible Side Effects____

Emergency Measures in Case of Serious Effects:________________________________

____

Other Instructions:____

____

I certify that valid health reasons exit requiring that the medication be administered during the school hours or during such a time that the student is under supervision of school officials.
I request and authorize that the above named student be given the above-identified medication in accordance with the instructions indicated.

________________ ____
Date of Signature Physician's Signature

Telephone____________________ ____
Name (print or type)

Please send or FAX completed form to:

- Lynden Christian School, 503 Nooksack Avenue, Lynden, Washington 98264, (360) 354-3358
- FAX (360)354-6690