

**LAKE HIGHLAND PREPARATORY SCHOOL  
MEDICATION ADMINISTRATION FORM  
FOR PARENT SUPPLIED MEDICATIONS (OTHER THAN TYLENOL)**

DATE: \_\_\_\_\_

I hereby give permission for my child, \_\_\_\_\_, (GRD/SEC \_\_\_\_\_, TEACHER \_\_\_\_\_) to have the following medication administered by the school nurse, or designated school personnel during the school day.

Name and dose of medication: \_\_\_\_\_

Time to be given: \_\_\_\_\_

How soon can the medication be repeated: \_\_\_\_\_

Date to begin: \_\_\_\_\_ Stop date: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

*If medication to be provided "when needed", describe indications:*

Signed: \_\_\_\_\_

**PHYSICIAN signature – not required if medication is in the bottle from the Pharmacy with the child's name and the name and dose of the medication**

Signed: \_\_\_\_\_

**PARENT signature required for ALL MEDICATIONS**

**NOTE:**

*SEE REVERSE SIDE OF THIS FORM FOR MEDICATION ADMINISTRATION POLICY*

1. ALL PRESCRIPTION MEDICATIONS MUST HAVE A PHYSICIAN'S AND PARENT'S SIGNATURE.
2. All medications administered at school must be checked in at the clinic with the required authorization.
3. Medication must be received in it's original container and be labeled with the student's name.
4. This authorization is valid only for the current school year and must be renewed.
5. This form may be faxed to the Lower School Office at 407-206-2854.

**OFFICE USE ONLY:**

- In student's backpack
- In homeroom classroom
- In Middle School office
- In Upper School office
- In Clinic