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 its 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