Medication Administration Consent & Licensed Prescriber Order

Name of Student:_____Date of Birth_____

Diagnosis: _____

Known Medication Allergies:_____

Name of Medication	1)	2)	3)	Tylenol/Motrin (Circle one if necessary)
Amount of medication				
Time of Administration				
Route of Administration				
Possible Side Effects				
Special Concerns or Comments				
Student capable of self-administering medication	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)
Student may carry medication on person	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)	Yes No (Circle one)

Legal Prescriber's Printed Name_____

Signature_____Date_____

Address_____Telephone_____

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1) **No medication will be given without an order signed by the legal prescriber.**
2) **All prescription bottles must be labeled by the pharmacy with a current date, the name of the student, the name of the medication, the strength of the medication, and the time to be given.**
3) **All non-prescription medication must come to school in its original packaging.**
4) **Any change in dosage or addition of new medication must be accompanied by a written legal prescriber's statement.**

I hereby request that my student be administered his/her medication by the school personnel authorized by the principal/supervisor. I understand that the medication will be administered as per the instructions of my above-named physician. I will notify the school of changes or discontinuation of this medication(s).

Parent/Guardian Signature_____Date_____

I request (name of student)_____be allowed to self-administer and carry the above medication at school according to school policy.

Parent/Guardian Signature_____Date_____

LISD District Nurse: Brittney Hauch 517-265-1689 Fax: 517-263-2890