LAKEHURST ELEMENTARY SCHOOL

AUTHORIZATION FOR MEDICATION-TO BE COMPLETED BY PHYSICIAN

Student: _____ **D.O.B.:** _____/_____/_____

It is necessary for this student to receive the following medication during school hours:

Medication: _____

Administration start date: _____ **discontinue date:** _____

Dose & Route: _____ **time:** _____

Diagnosis: _____

Possible adverse medication reactions: _____

Class trips: ***When a parent/guardian or nurse is unable to attend class trip (please check one)***

- ☐ **The medication can be withheld on the day of the class trip**
- ☐ **The time of administration can be adjusted with the parent/guardian**

Office Stamp

_____

Healthcare Provider Signature

_____ _____

Healthcare Provider Printed Name **Date**

Parent/Guardian Request Section: ***Please read and sign/date***

I give permission to the school nurse to administer medication to my child as prescribed above. I also give permission for the exchange of information between the school nurse and my child's healthcare provider concerning my child's health and treatment. I understand that the Lakehurst School District or school nurse shall have no liability as a result of any injury arising from the administration of the above named medication and that they shall be held harmless against any related claims.

- ☐ **Yes, I want medication to be given on early dismissal half) days.**
- ☐ **No, I do not want my child to be given medication on early dismissal (half) days.**

_____ _____/_____/_____

Parent/Guardian signature **Date**