Lake Station Community Schools
Prescription Medication Permission Slip
***PRESCRIBING PHYSICIAN TO COMPLETE**

Student Name:_____ Date of Birth:_____

Medication:_____ Quantity:_____

Dose and Frequency:_____

Length of Treatment:_____

Prescribing Physician:_____

Physician Phone number:_____

Physician Address:_____

Physician Fax:_____

Reason for Medication:_____

Please indicate by **circling** yes or no the following:

Is this medication an emergency medication? Yes No
Is this student able to correctly administer medication by themselves? Yes No
Is this student able to carry emergency medication on self? Yes No

By signing below you, the Prescribing Health Care Provider, are indicating the need for this prescription medication to be taken during school hours. This form also serves as parental consent for exchange of information between the school nurse and the prescribing physician for clarification of administration and report of response to medication or adverse effects. Please note that for safety reasons **only emergency medications** may be carried on the child themselves during school hours **all** other medications will be held in the Nurse's office for use by the student as prescribed by you, the Prescribing Health Care Provider.

Signature of Prescribing Health Care Provider:_____

Date:_____

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Please use ink only

***PARENT/LEGAL GUARDIAN**:

I,_____,the parent/legal guardian of ,_____, give Lake Station Community Schools Staff permission to administer the above prescribed medication according to the directions provided by the Prescribing Physician. It also indicates an understanding that the medication must be provided to us in the original bottle with the label from the pharmacy. It is the parent/guardian responsibility to keep school records updated. If there are changes to the medication or dosing, or if the medication is stopped, we need to be notified immediately of the changes and a new permission slip must be filled out by both the Prescribing Physician and yourself.

Please Initial the Following:

_____ This form serves as parental consent for exchange of information between the school nurse and the prescribing physician for clarification of administration and report of response to medication or adverse effects.

_____ This form gives the school permission to work with insurance case managers, if applicable, to provide the best care possible for your student should the need arise.

_____ I understand that my student has a chronic condition that requires medication and should they have the opportunity to attend school sponsored trips I will be afforded the opportunity to accompany my child, as long as a background check is on file with the school, at my own expense should fees apply.

_____ I understand that if I should choose to not attend the school sponsored trip the health services staff or the delegate of the District Nurse will be provided to attend to my student's needs during the trip.

I thank you for your cooperation and understanding.

Printed Parent Name:_____ Student Name:_____

Parent Signature:_____ Date:_____

Sincerely,

Jennifer Pavlinac RN, BSN
Director of Health Services
Lake Station Community Schools
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