# LE MARS COMMUNITY SCHOOLS

# PARENTAL AUTHORIZATION AND RELEASE FORM

# FOR THE ADMINISTRATION OF MEDICATION TO STUDENT

Student_________________________________________Age_____Grade_____Building__________

It is necessary he or she receive the following medication at school:

Name of Medication____________________________________________________________

Dosage of Medication___________________________________________________________

Time of Medication_____________________________________________________________

Reason for Medication__________________________________________________________

Physician/Dentist_____________________________________________phone___________

Name of Pharmacy____________________________________________phone___________

I request that the prescribed drugs or medication be dispensed according to the written directions. I request that this medication be given by a qualified staff person. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

**I acknowledge that medication will not be given if it has expired or it has an improper label. Please check the container before sending it to school and send the new prescription bottle each time you bring medication to school.**

Parent/Guardian Signature_______________________________________________________

Date______________________________ Home/Cell #________________________

Work #__________________________

Suggestion: When you pick up your child's prescription, ask your pharmacist for a bottle labeled for school use.

# PRN / Temporary Medication Record

Student ______________________ Grade ________

Medication ______________________________ Dosage ______________

Method __________ Time ______________ Pharmacy ______________ Rx # ______________

Date to Begin ________ Date to End ________ Prescriber or person authorizing medication ______________

Reason for Medication ______________________________________________

| Date | Time | Dose | Initials | Comments |
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