

**LE MARS COMMUNITY SCHOOLS
PARENTAL AUTHORIZATION AND RELEASE FORM
FOR THE ADMINISTRATION OF MEDICATION TO STUDENT**

Student _____ 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: _____

Name of Pharmacy: _____

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 this 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 to school and send the new prescription bottle each time you bring medication to school.

Parent/Guardian Signature: _____ Date: _____

Cell/Home #: _____ Work #: _____

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