LACKAWANNA TRAIL SCHOOL DISTRICT
REQUEST TO ADMINISTER MEDICATION

In accordance with the recommendations of the Department of Health, students will be given prescription medication only on the direct written order of a physician. Before medicine can be administered in school, the following must be submitted to the School Nurse:

- Medications in their original containers, clearly labeled
- A physician's prescription
- This form with all appropriate information completed

Name of Student:_____

Name of Medication:_____

Reason for Medication:_____

Dosage to Administer:_____

Time to Administer:_____ AM or PM

Period to Administer: From ____/____/____ until ___/___/___

Physician: Name:_____

Address:_____

Phone:_____

Pharmacy: Name:_____

Phone:_____

The above mentions student must receive the above medication in order to maintain sufficient health to participate in the school program.

Signature of Physician_____ Date ___/___/___

Physician's Comments _____

_____

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Please administer the above mentioned medication to my child. I do hereby release, discharge and hold harmless the school district, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child.

_____ Date _____

Signature of Parent of Guardian

DAYS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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