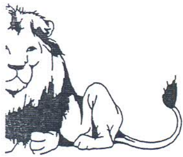

Lackawanna Trail Junior-Senior High School

"Home of the Lions"

PARENT/GUARDIAN PERMISSION: (to be completed by parent/guardian)
I give permission to the school nurse and to those persons she has in serviced to administer the medication(s) listed below.

Student Name: ______________________________
Signature of Parent/Guardian ____________________ Date________
Phone: ______________

PHYSICIAN'S ORDERS: (to be completed by student's physician)
1. Medication: ________________________________
Dose: ______________ Frequency: _____________
Diagnosis: ___________________________________
Side effects: _________________________________
Period of time to administer ________ to__________

2. Medication: _________________________________
Dose: _________________Frequency: ____________
Diagnosis: ____________________________________
Side effects: _________________________________
Period of time to administer ________ to__________

Any changes in medication or dose require written authorization.

Physician's Signature: ________________________Date:________
Physician's Printed Name: ________________________
Medical Group/Clinic Office Address: ________________
Office Phone: __________________________________
Fax Number:_______________________

Please return completed form to School Health Office

PO Box 85
Factoryville, PA 18419

570-945-5181 Fax: 570-945-3832

www.ltsd.org