INDEPENDENT SCHOOL DISTRICT NO. 1
Lewiston, Idaho 83501

SCHOOL MEDICATION FORM

Student ____

School ______________________________ Grade ____________

Address ____

Parents ____

Home Phone ____________________ Work Phone ____________________

TO AUTHORIZE SCHOOL PERSONNEL:

I hereby request and authorize ___ my child to self-administer[1], or ___ school staff to administer the following ___ prescription medication, or ___ over-the-counter medication.

Medication name: ______________________________________

Instructions: ____
(Dose) (Time)

and I release the school from liability should reactions result from medications. In case of emergency, follow-up care and transportation are to be as follows:

____

____

[1] Self-administration of some medications is not allowed. See the back of this form #15.

A physician's authorization is not required for over-the-counter medications.

____
Parent's signature

____
Date

TO AUTHORIZE SCHOOL PERSONNEL:

I prescribe (medication name) ______________________________

to be given to ____________________ by school personnel during school hours for the reason stated:

____

Possible side effects to be observed by school personnel: ______________________________

____

____
Physician's signature

____
Date

See "Medication Policy" on the back of this form.

(9/04) Distribute copies to: School and Parents