Lancaster ISD

School Health Services

MEDICATION ORDERS/AUTHORIZATION/CONSENT

Student's Name_____ Sex_____

Date of Birth ____ /____ /_____ Teacher/Homeroom_____

Condition for which medication is being administered_____

Medication Name_____ Dose_____ Route_____

Times(s) of day to administer_____

Medication shall be administered from: ____ /____ /_____ to: ____ /____ /_____

Possible side effects_____

Special requirements for administration/storage_____

Known Food or Drug Allergies YES / NO If Yes, please explain_____

Health Care Provider's Name_____ Telephone____ - ____ - _____

Address_____

Prescriber's Signature_____ Date_____

Parent /Guardian Authorization

I _____ parent / guardian of _____request that school health staff administer the medication as described above by my child's health care provider. I consent to medication administration for my child and agree to review and provide any special instructions for the administration of my child's medication, and share that information with my child's school health staff.
I understand that any changes to this order requires a new written order from the health care provider.

Parent/Guardian Signature_____ Date_____

Cell Phone____ - ____ - _____ Home Phone ____ - ____ - _____ Work Phone ____ - ____ - _____

Staff Review

Medication was received from_____ Date_____

Medication was received by_____ Date_____

Initial Count (pills or tablets) or Measurement (liquids) _____

Witness Signature_____ Date_____