

Lamoni Community School District
Authorization for Administration of Medication

_____/_____/_____
Student's Name (Last, First, Middle) Birthdate Date Grade

Medication Information:

Medication: _____

Dose: _____

Time: _____

Reason: _____

Name of Student's Provider: _____

Phone number of provider: _____

Name of Clinic: _____

Parental Authorization: I request the above student be given the medication at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that exchange of information may occur with the prescriber as needed and that medical information can be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

Parent/Guardian Signature _____

Date _____

Parent/Guardian- home/cell phone _____

****This authorization must be signed/dated by the parent or guardian.***

****The medication MUST be in its original container as dispensed by the pharmacy or the manufacturer's labeled container.***

****The medication label must contain the student's name, date, name of the medication, and directions for use.***