

*A school administrator, teacher, or other school employee designated by the school administrator, who in good faith administers medication to a pupil in the presence of another adult or in an emergency that threatens the life or health of the pupil, pursuant to written permission of the pupil's parent or guardian, and in compliance with the instructions of a physician, physician's assistant, or certified nurse practitioner is not liable in a criminal action or for civil damages as a result of an act or omission in the administration of the medication, except for an act or omission amounting to gross negligence or willful and wanton misconduct.*

## L'ANSE CREUSE PUBLIC SCHOOLS STUDENT MEDICATION PARENTAL PERMISSION FORM

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary prescribed medication to students. All medications must be in the original container, clearly labeled, indicating the following information: **Student's name, prescription number, medication name, dosage, date issued, doctor's name, pharmacy name, address and phone number.**

1. Name of Student \_\_\_\_\_  
(First) (Middle) (Last)

2. School \_\_\_\_\_ Grade \_\_\_\_\_ Room \_\_\_\_\_

3. Name of Medicine \_\_\_\_\_ and/or Prescription No. \_\_\_\_\_

**30 day renewal of medication: same medication/same dosage:**

Prescription No: \_\_\_\_\_ Date: \_\_\_\_\_ Total Tablets \_\_\_\_\_

Prescription No: \_\_\_\_\_ Date: \_\_\_\_\_ Total Tablets \_\_\_\_\_

4. Date school personnel may begin administering medicine: \_\_\_\_\_  
(Month - Day - Year)

5. Times of day medicine is to be administered: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

6. This medicine is prescribed by Doctor \_\_\_\_\_

Doctor's Address \_\_\_\_\_

City and State \_\_\_\_\_

Telephone Number \_\_\_\_\_

7. Directions and Procedures for administering medicine: **Must be the same as on the medicine container.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. I understand this medicine will be located in the school office area. I understand that it is the responsibility of my child to report to the office for his/her medication. I further understand that it is my responsibility to notify the school of change or discontinuation of the medication.

**Parent/Legal Guardian must sign in presence of school personnel.**

Signature of Parent/Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

**A NEW FORM MUST BE COMPLETED WHEN THERE IS A CHANGE IN MEDICATION, DOSAGE OR TIME MEDICATION IS TO BE ADMINISTERED.**

Student's Name: \_\_\_\_\_

**MEDICATION GIVEN**

	Date	a.m.	p.m.	Tablets Remaining	Initials	Initials		Date	a.m.	p.m.	Tablets Remaining	Initials	Initials
1.							26.						
2.							27.						
3.							28.						
4.							29.						
5.							30.						
6.							31.						
7.							32.						
8.							33.						
9.							34.						
10.							35.						
11.							36.						
12.							37.						
13.							38.						
14.							39.						
15.							40.						
16.							41.						
17.							42.						
18.							43.						
19.							44.						
20.							45.						
21.							46.						
22.							47.						
23.							48.						
24.							49.						
25.							50.						