

Lancaster Community School District

Students

**PRACTITIONER ORDER FOR MEDICATION ADMINISTRATION**

To be completed by practitioner

Name of student \_\_\_\_\_

Name of medicine \_\_\_\_\_

Amount to be given \_\_\_\_\_

Time of day to be given \_\_\_\_\_

Number of days to be given \_\_\_\_\_ Short term \_\_\_\_\_ Long term

Date \_\_\_\_\_ Signature of practitioner \_\_\_\_\_

To be completed by parent/guardian

The medicine to be furnished by the parent/guardian is to be in the original prescription bottle labeled with the name of the medicine, the amount to be given, time of day to be given and the expected duration of treatment. The practitioner's name must be on the label.

- I hereby give my permission to the school to give the medication to my child according to the directions stated above.
- I further agree to hold the school and personnel giving medication harmless in any and all claims arising from the administration of this medication at school.
- I agree to notify the school in writing when any change in the above orders is necessary.

Reason for Medication

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Administering Person's Signature \_\_\_\_\_

EXHIBIT APPROVED: January 9, 1985

EXHIBIT REVISED:

