

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:

