LANCASTER SCHOOL DISTRICT

Laurie Walker, Lancaster School Nurse

861 West Maple Street

723-4066 Ext. 106

PRESCRIPTION MEDICATION FORM

The following section is to be completed by the parent:

☐Winskill ☐Middle School ☐High School

Child's Name: _____

Last First Sex Birth date

_____

Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to self medicate her/himself using their inhaler as also authorized by me and my physician (see below).

_____

Date Parent/Guardian signature

The following section is to be completed by the PHYSICIAN:

DIAGNOSIS for which medication is given _____

Name of Medicine _____

Dose _____

Route _____

Time and Frequency _____

If an inhaler is ordered can the student carry the inhaler on them and self medicate? ☐ Yes ☐No

List significant side effects: _____

Length of time treatment is recommended at school _____

Other Information : _____

_____

Date: Physician's Signature _____