Lancaster Mennonite School

MEDICATION CONSENT FORM (08-03-2017)

Signed by Physician and Parent

We understand that the administration of medication during the school day is sometimes unavoidable. For the protection of your child and to be in compliance with standards, Lancaster Mennonite will dispense prescription or over the counter medications only with the signed consent of the student's parent/guardian and physician. For your child to receive any medication during the school day the information below must be completed by both you and your child's physician. You will be notified if your child receives an over the counter medication during the school day. All medication must be provided by you and must be in the original container with your child's name clearly marked on the container.

Parent/Guardian Consent:

I give permission for my child, ____, to receive the medication listed below and as set forth below during the school day. I understand that the medication will be given by school staff according to my child's physician's directions. I understand that staff other than the school nurse may administer the medication and may not be trained in the administration of medication. I knowingly consent to this procedure and request that the medication be administered. I knowingly consent to this procedure and request that the medication be administered. I agree to release LM of any liability and hold LM harmless for the administration of the medication as set forth below. I understand and accept that the Lancaster Mennonite School Board and its employees are not responsible for any effects of or reactions to the medication administered.

____ ____________

Signature of Parent/Guardian **Date**

Licensed Prescriber Medication Order:

Patient's Name: ____ Date: ______________

Name of prescription or over the counter medication: ____

Dosage: ____

Time of administration: ____

Directions: ____

Possible Side Effects/Interactions with Other Medication: ______________________________________

Known Allergies: ____

Discontinuation Date: ____

Physician signature: ____

Physician name printed: ____

Practice Name and Phone Number: ____

Additional Information: ____

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