Lakeland Christian School Authorization for Medication

The following section is to be completed and signed by the **PARENT:**

A new authorization must be completed at the beginning of each school year or anytime a dosage is changed.

Child's Name: ______________________________ Sex: ______ Grade:_______ Date of Birth: ____________

Physician's Name: ____ Telephone: (____) ________________

Physician's Address: ____ Fax: (____) ______________________

I hereby authorize the above named physician and Lakeland Christian School staff to reciprocally release verbal, written or faxed protected health information (PHI) regarding the above named child for the purpose of giving necessary medication and/or treatment while at school. I understand PHI is confidential and is protected by the Health Insurance Portability and Accountability Act (HIPAA).

I request that my child be administered and/or assisted in taking the medicine(s) described below at school by authorized persons as permitted by me and my physician (see below).

Date: ________ Parent/Guardian Signature: ____

Home Phone: (____)_________________________ Emergency Phone: (____)___________________________

The following section is to be completed by the **PHYSICIAN**

Diagnosis for which medication is given: ____

Name of Medication: ____

Form: ____

Dose: ____

If is to be given at school, at what time? ____

If medicine is to be given "AS NEEDED", describe indications:____

____

How soon can it be repeated? ____

List significant side effects: ____

Length of time this treatment is recommended: ____

Other information: ____

____

Date: ________ Physician's/Mid-level Practitioner's signature:___________________________________

For School Use Only:

Amount of Medication in clinic:_________________________ Verified by: __________________________

Adapted from the American College of Allergists