LISBON EXEMPTED VILLAGE BOARD OF EDUCATION

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STUDENT MEDICATION FORM

NAME: ______________________________
ADDRESS: ______________________________
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TELEPHONE: ______________________________
GRADE: ______________________________
HOME ROOM: ______________________________

NOTE: Sections I and II must be completed prior to the dispensing of any medication or medical procedures.

SECTION I. PARENT STATEMENT AND AUTHORIZATION

A. I understand that it is my responsibility to deliver any and all medication in the original prescription bottle to school personnel.

B. I understand that it is my responsibility to notify the school of any changes of the medication, dosage, or procedure.

C. I understand that it is my responsibility to provide any and all necessary refills of medications.

Signature of Parent/Guardian: ______________________ Date: ______________________

SECTION II. STATEMENT BY PHYSICIAN

A. The above named student is under my care and I have prescribed the following medication/s for him/her:

Prescription	Dosage	When Administered

B. The student is being prescribed this medication for:

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C. Please indicate any possible reactions which should be reported to you.

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D. Please indicate any special instructions regarding the storage of this medication.

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E. Please indicate the expiration date of this request

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Physician's Signature: ______________________ Date: ______________________

Physician's Telephone Number ______________________________

The school nurse will be responsible for contacting the parent or guardian in regard to any medical questions which arise from school personnel, and will also be responsible for notifying the parent or guardian or physician of any adverse reactions.