LENOX PUBLIC SCHOOLS

This form is to be completed by Parent/Guardian & Signed by Physician

Authorization for Medication To Be Taken During School Hours

SCHOOL: ☐ **MORRIS** ☐ **LMMHS** **School Year:** _____

STUDENT'S NAME:_____
DATE OF BIRTH:_____

PHYSICIAN/DENTIST:_____
ADDRESS_____
TELEPHONE:_____FAX:_____

I request that authorized school personnel give my child the over-the-counter medicines checked from list below.

☐TYLENOL ☐ADVIL ☐OTHER: _____

Special Exception: Inhalant Medications for exercise-induced asthma only.
Is child permitted to medicate him/herself?
Parent/Guardian Response *Yes* ☐ *No* ☐ ***Physician Response:*** *Yes* ☐ *No* ☐

Diagnosis for which prescription medication is given _____

Name of medication: _____
Administration Route:_____ Dosage:_____
If medicine is to be given daily, what time should it be given?_____
If medication is to be given "WHEN NEEDED", describe indications:_____

Length of time treatment indicated: _____
How soon medicine can be repeated: _____
List significant possible side effects: _____

Physician or Dentist signature_____ Date _____
Parent/Guardian signature _____ Date _____