Lisbon Regional School
Prescription Medication Release Form

If your child needs to take any prescription medication while at school, we need to have a physician's order and a parent/guardian authorization in order to administer the medication.

Name of Student: _____DOB_____ Grade: _____

Physicians Order

I hereby request and authorize you to give:

Medication _____

Dosage _____

Time given _____

In effect until _____

Diagnosis/medical reason for medication:

_____

Any special side effects, contraindications, and adverse reactions to be observed:

_____

****If an AM dose is omitted, a dose of ____mg/ml may be given at school after omission is verified by parent/guardian.**

_____	_____	_____
Physician's Name/ Print	**Physician's name/ Signature**	**Date**

1. I request that the above medication be given during school hours as ordered by this student's physician
2. I release school personnel from any liability in relation to this request when the medication is given as ordered.
3. We will notify the school of any change in the medication (dosage change, medication is discontinued before time stated in MD order.)
4. I give permission for the school nurse to communicate with appropriate staff about this medication.
5. **Field Trips:** I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
6. **Medication will not be given without the proper container.**
7. **CHILDREN ARE NOT TO TRANSPORT MEDICATION TO AND FROM SCHOOL.**
   AN ADULT MUST DELIVER THE MEDICATION TO THE HEALTH OFFICE.

Parent/Guardian Signature: _____**Date:** _____

Phone #_____