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Pinckney, MI 48169
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LIGHT OF THE WORLD ACADEMY

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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student Last Name:_______________________ First Name:_______________________

Date of Birth:__________Classroom__________________Teacher(s)__________________

Physician's Order (*to be completed by physician or authorized prescriber*)

Diagnosis/Purpose of Medication:____________________/______________________

Name of Medication:____________________________Dosage:______________________

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other______________

Frequency:________________Time of Day:____________Anticipated Duration:______________

This prescription is: ______Initiation of Therapy ______Adjustment of Dosage

______Maintenance Dose ______Discontinuation of Therapy

Important side effects or restrictions:____

Start: ☐ Date form received Other dates:_____________________________

Stop: ☐ End of school year Other date/duration:_____________________________

☐ For episodic/emergency events only

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other_____________________

This student is both capable and responsible for self-administering this medication:

☐ No ☐ Yes-Supervised ☐ Yes-Unsupervised Student may carry this medication: ☐ No ☐ Yes

Physician's Signature:____________________________Phone:__________Date:______________

Physician's Name:_______________________________Address:_______________________

The undersigned parents/guardians authorize Light of the World Academy, through its office staff, building level principal/secretary, to administer medication or to supervise the taking of medication by my child.

It is understood that the undersigned parent/guardian shall immediately notify the school district in writing in the event the prescription shall be discontinued or modified.

The medication must be brought to school by a parent/guardian in the original pharmacy bottle, appropriately labeled. The medicine must be kept locked in the school office. Refill of the prescription shall be the responsibility of the parent/guardian.

Further, the undersigned releases the school district and shall indemnify said school district from any liability or damage which may result to the student from the administration of said medicines as prescribed by the physician.

Parent/Guardian Signature:_______________________________Date:_____________________

Home Phone:___________________________ Daytime Phone:___________________________