

Request for Medication to be Given During School Hours

| To be Completed/Signed by Physician: | |
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| Name of Student: | School: Lincoln Charter School |
| Medication: | Dosage/Route: |
| (No injection will be give | except in extreme emergency, such as allergy to bee stings) |
| Time(s) Medication is to be given at school: | pm |
| To be given from (date) | to (date) |
| Significant Information: (e.g., purpose of medical | tion, side effects, any special instructions for giving at school, contraindications): |
| Would it be acceptable to keep the medication | in the school's main office? |
| | (All medications are held under lock and key in Main Office's) |
| | dian within a container properly labeled by a pharmacist with identifying dispensed, dosage prescribed, and the time it is to be given). Over-the-counter led with the student's full name. |
| Physician's Signature: | Date: |
| Group/Practice Name: | Phone #: Fax # |
| medication and self-medicate as prescrib | eabove named student should and is responsible enough to carry his/her own ed. I have provided education to the student on indications for the use of the dication and methods of administration. |
| Physician's Signature: | Date: |
| | Parent's Permission |
| school undertakes no responsibility for the admi | I named above to receive medication during school hours. I understand that the nistration of the medication. This medication has been prescribed by a licensed and their agents and employees from any and all liability that may result from my |
| Reviewed By School Personnel: | Signature of Parent/Guardian & Telephone Number |
| Signature (who reviewed/received) | |
| Date (medication & form received) | Expiration Date of Medication Date this form was complete |
| DENVER CAMPUS 7834 GALWAY LANE DENVER, NC 28037 | LINCOLNTON CAMPUS 133 EAGLE NEST ROAD LINCOLNTON, NC 28092 |