THE LOWELL SCHOOL
PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent:

I request that my child _____ D.O.B. _____receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

☐ I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field tips to my self-directed child.

Signature (Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

I request that my patient as listed below, receive the following medication:

Name of Student: _____ D.O.B.: _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

•Possible Side Effects and Adverse Reactions (if any): _____

_____

_____

Physician's Signature: _____ Date: _____

Address: _____ Phone: _____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult

Plan reviewed with parent(s)/guardian(s): _____

Parent Signature: _____ Date: _____