LINCOLN PARK PERFORMING ARTS CHARTER SCHOOL

Health Services 724-643-9004 Ext. 1685 FAX 724-643-2171

AUTHORIZATION for MEDICATIONS AND TREATMENTS

THE FOLLOWING IS TO BE COMPLETED BY THE PARENT/GUARDIAN:

Student's Name_____ DOB_____ GRADE_____

Physician's Name_____Phone_____

Physician's Address_____Physician's Fax_____

I give permission for the school nurse or designee to administer this medication and/or treatment as prescribed. I give permission for the school nurse to contact the child's physician as needed to further clarify the medication/treatment order. I release the Lincoln Park Performing Arts Charter School and its personnel from any liability for damages that our child could incur as a result of this request.

Student will carry inhaler and/or epi-pen with him/her and is capable/permitted to self-administer YES_____NO_____

ALL medications **must** be brought to the health office in the original container.

Parent/Guardian Signature_____Date_____

Phone (H)_____(Cell)_____(e-mail)_____

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN:

It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the student receive the medication during school hours, please complete the following information:

Diagnosis for which medication/treatment is given:_____

Name of medication(s)/treatment:_____

Dose:_____Time to be given:_____Duration:_____

Significant side effects:_____

Procedure to follow if an adverse reaction should occur:_____

Student is capable of self-administration (Epi-pen and Inhaler ONLY) : YES_____NO_____

Physician Signature:_____Date:_____