Lawrence School
Great Minds Don't Think Alike

ADMINISTRATION OF PRESCRIPTION MEDICATION *DURING* THE SCHOOL DAY

(ONE FORM PER MEDICATION)

ALL MEDICATION MUST BE IN THE *ORIGINAL* CONTAINER

SECTION I – TO BE COMPLETED BY PARENT

Student Name_____

Date of Birth_____ Age_____ Current Grade_____

Parent Daytime Phone #_____

Known Allergies_____

----Please regard my signature below as my assurance that I release Lawrence School, PSI, and any or all of the school's and PSI's officers and employees from any liability or damages resulting from the consequences of adverse reactions of our child taking or failing to take his or her medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I also understand that **the medication must be provided to the school in the original prescription bottle**.

Parent/Guardian's Printed Name_____ Tel #_____

Parent/Guardian's Signature_____Date_____

SECTION II - TO BE COMPLETED BY PHYSICIAN / PRESCRIBER

Name of Medication and Dosage_____

Time(s) of Day Medication to be Administered_____

Date to Begin Medication_____ Date to End Medication_____

Possible Adverse Reactions, if any_____

Special Instructions, if any_____

The medication can be safely administered by non-medical personnel: ____Yes ____No

----My signature below verifies that this child is a patient/client of mine and that the medication detailed above needs to be administered during school hours. I agree that this medication is safe and appropriate for use with this child and that I have reviewed the information provided by the parent/guardian in Section I for accuracy.

Physician/Prescriber's Printed Name_____ Tel. #_____

Physician/Prescriber / Signature_____ Date_____