Leyton Public Schools
Prescription Medication Authorization Form:

- Any chronic condition requiring medication during school hours MUST HAVE written instructions from the attending physician for administration to the child by the school nurse, or trained personnel.
- Any medication that is brought to the school to be given to the child **MUST be in the original container with proper label including student's name, provider's name, medication name and instructions for use.**
- **This authorization must be renewed on an annual basis or prescription changes.**
- **Medication will not be administered without the parent AND physician consent.**

Student Name:______________________________________DOB:__________________Grade:________

Medication's Name:____

Dose:______________________________________ Route:_____________________________________

Time to be Given:____

Diagnosis:____

Side Effects:____

Special Instructions:____

Start Date:___________________________________End Date:______________________________________

I understand I am to provide this medication and maintain the supply as needed, and to notify the school in writing of any changes in the medication.

I hereby give consent for Leyton Public Schools to administer this student the above medication, and for the school and health care provider to share information regarding this medication. I release Leyton Public Schools and employees from liability in case of choking, allergic reaction, side effects and/or any health risks related to this medication.

Signed:____Date:_____________________

Parent/Guardian Signature

Signed:______________________________Printed Name:_______________________Date:___________

Physician/Health Care Provider   Physician/Health Care Provider