To be completed by the **Physician** or **authorized prescriber / Parents or guardian** signature required

PRESCRIPTION MEDICATION CONSENT FORM
LINCOLN SECONDARY LEVEL

Student:_____ Grade:_____ School Year:_____

Name of medication: _____ Diagnosis: _____

Dosage/ Route: _____ Time to be given at school: _____

Start: ( ) Date form received. Other date: _____

Stop: ( ) End of school year. Other date: _____

Special requirements pertaining to Inhalers and Epi-pens:

* This student is both capable and responsible for self-administering his / her Inhaler / Epi-pen. ( ) Yes ( ) No
* This student may carry his / her Inhaler / Epi-pen. ( ) Yes ( ) No

A student may transport his/her own medication (including controlled substances) to school but must deliver the medication to the school nurse-teacher upon arrival.

Date:_____ **Physician's** signature: _____ Phone: _____

Date: _____ **Parent's or guardian's** signature: _____ Phone:_____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Initials	Signature	Initials	Signature	Codes
				A: Absent N: No Show
				F: Field Trip O: No Medication
				H: Hold X: Weekend / Vacation