Lancaster ISD

School Health Services

OVER THE COUNTER MEDICATION
PERMISSION TO ADMINISTER

MEDICATIONS WILL BE GIVEN FOR ***2 WEEKS ONLY***

NAME OF STUDENT: _____

MEDICATION: _____

DOSAGE/ROUTE: _____

DOCTOR: _____PHONE #:_____

PARENT/GUARDIAN: _____PHONE #:_____

POSSIBLE SIDE EFFECTS: _____

I UNDERSTAND THAT NEITHER THE PERSON ADMINISTERING THE ABOVE MEDICATION OR THE LANCASTER INDEPENDENT SCHOOL DISTRICT WILL BE HELD RESPONSIBLE OR LIABLE FOR ANY SIDE EFFECTS OR PROBLEMS RESULTING FROM THE GIVEN MEDICATION.

PARENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____DATE:_____