



Lincoln County School District #2  
360 Jefferson  
Afton, WY 83110

**PERMISSION FOR ADMINISTRATION OF MEDICATION AT SCHOOL AND RELEASE OF  
LIABILITY**

**An adult must bring medication to school in a pharmacy labeled container. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or instructions for administration. An adult must pick up the medication at the end of the school year, otherwise it will be discarded.**

**Student Information**

**School Year:** \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Teacher / Grade: \_\_\_\_\_  
Medication Allergies: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER**

Reason for Medication: \_\_\_\_\_  
Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Time / Frequency of administration: \_\_\_\_\_  
If PRN, Frequency: \_\_\_\_\_ For Symptoms: \_\_\_\_\_  
Medication to be administered: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Restrictions and/or important side effects: ☐ NONE  
☐ If YES, specify: \_\_\_\_\_

**Self Carry / Self Administration:**

May self-carry: ☐ YES ☐ NO

Student is capable of appropriate and accurate self-administration: ☐ Supervised ☐ Unsupervised

**Prescriber Information and Signature**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name/Title: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

**TO BE COMPLETED BY PARENT / GUARDIAN**

**Permission from Parent / Guardian**

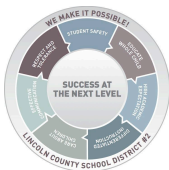
I, \_\_\_\_\_, request and give permission for:

1. trained school personnel, to give my child (named above) the listed medication according to school board policy.
2. the school nurse to contact the health care provider named above or the pharmacist to discuss the medication and my child's health.

I agree to indemnify and hold harmless LCSD2 and its employees against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_



Lincoln County School District #2  
360 Jefferson  
Afton, WY 83110

**PERMISSION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION AT SCHOOL  
AND RELEASE OF LIABILITY**

**Student Information**

**School Year:** \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Medication Allergies: \_\_\_\_\_

**Permission must be given by Parent/Guardian for any and/or all medications**

Please **place a check mark** in the box next to each medication your child is authorized to receive from the trained school personnel:

**(Dose will be based on age / weight per guidelines from the American Academy of Pediatrics)**

- Acetaminophen (generic for Tylenol)
  - ☐ Acetaminophen tab
  - ☐ Chewable acetaminophen
- Ibuprofen (generic for Advil/Motrin)
  - ☐ Ibuprofen tab
  - ☐ Chewable ibuprofen
- Allergy Relief / Cetirizine (generic for Zyrtec)
  - ☐ Cetirizine tab
  - ☐ Liquid cetirizine
- ☐ Tums (antacid)
- ☐ Cough drops
- ☐ Saline
- ☐ 1% Hydrocortisone cream
- ☐ Bacitracin antibiotic ointment

**Parent contact at time of administration**

1. For oral medication (tylenol, ibuprofen, zyrtec, tums) - written consent required AND
  - a. For students **KG-6th** grade: Parents will be contacted prior to administration
  - b. For students **7th-12th** grade:
    - ☐ Parent DOES request contact before administering
    - ☐ Parent DOES NOT requested contact
2. For topicals, saline, and cough drops - parents will NOT be contacted prior to administration.

**Permission from Parent/guardian**

I, \_\_\_\_\_, request and give permission for trained school personnel, to give my child (named above) the listed medication according to school board policy and standing orders.

I agree to indemnify and hold harmless LCSD2 and its employees against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_