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: _____