## **LPS Medication Administration Authorization Form**



Child's Name:		Birth date:	SCHOOLS
School:			
Medication:			
Dosage/Amount:			
To be given at the following time(s):			
Purpose of medication:			<del></del>
Side effects that need to be reported:			
Starting Date:E	nding Date:	_	
Storage Requirements:			
Sign atoms of Health Come Duravidan or	ith Dussesintins Anthonia	License Numbe	
Signature of Health Care Provider w	ith Prescriptive Authority	License Numbe	r
Print name of Health Care Provider Prescription medication:		Phone Number	Date
Over the counter medication:  Must be packaged in the off off of safety reasons, parent of the packaged in the off of safety reasons, parent of the packages that require a table or pills.  Unused medication that is new medication administry dosage and at the beginning dosage and at the beginning the said institution and their personnel from any failure to administer) the medication to the studing information about the administration of this medication about the administration of the safety of the medication about the administration of this medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the administration of the safety of the medication about the safety of the medication and the safety of t	anot picked up by the parent will ration authorization forms must be not got each school year.  edication prescribed by a licensed accommodation to, the undersigned amployed by Littleton Public School legal claim(s) which they now have lent. By signing this document, I guedication with the school nurse or	with the child's name child's medication to the s by the pharmacist or pare be discarded at the end of the completed each time then the chealthcare provider. It is unally parent or guardian. In consols, the undersigned parent of the complete parent of the parent of the complete parent of the parent of	the school staff may not split tablets the school year. The are any changes in medication or the acceptance of the core guardian hereby agrees to release ising out of the administration of (or as health care provider to share sminister medication.
ParentGuardian Name (Printed)	Parent/Guardian S	ignature	Date
Phone	Alternate Phone		
For School RN use only:			
Nurse Signature	Date		
School Copy PMT Scann	ned IC upload		