



LUFKIN ISD HEALTH SERVICES
Jan Fulbright ~ Director of Health Services
936.633.7264

PRESCRIPTION MEDICATION AUTHORIZATION

I give my permission for LISD to give my child: _____

The following medication: _____

DOSAGE: _____

WHEN TO GIVE: _____

DATE TO START: _____

REASON: _____

I hereby release Lufkin ISD from liability to allergy or reaction to said medication.

Parent or Guardian Signature

Date

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER WITH LABEL INTACT. The label must not be altered. Parent directions must match label directions. The dosage must be appropriate for your child's age.

NOTE: All medication will be kept locked in nurse's office. Asthma inhalers may be self-administered if deemed necessary by your doctor. Please have your doctor sign below if this is necessary or bring a note signed by him stating the need for your child to self-carry his/her asthma inhaler.

Due to the above named students medical condition, I am authorizing him/her to self-carry and self-administer his/her asthma inhaler.

PHYSICIAN'S SIGNATURE

ATTACH PRESCRIPTION CHANGES BELOW