AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICINE
LAFAYETTE CHRISTIAN ACADEMY
220 Portland Avenue, Lafayette LA 70507
Phone: (337) 234-9860, Fax: (337) 233-3555

THIS SECTION TO BE COMPLETED BY PHYSICIAN

This request is to be effective for the school year 20__-20__ or earlier stop date: _____
Student's Name: _____ DOB or Age: _____
Medication: _____
Generic Name (If Used): _____
Dosage Amount: _____ Time to be administered at school: _____
Condition for which drug is to be given: _____
Note any side effects: _____

INHALANT PRESCRIPTIONS

This student is both capable and responsible for self-administering this medication:

_____ No* _____ Yes-Supervised* _____ Yes-Unsupervised (student can carry)

*Cannot be carried by student - inhalant will be kept in the school office and/or After School Care

My child and I understand that if this medication is taken without our consent by another person/student, we will accept full responsibility for any complications that may arise from the usage of this prescription.

_____
Parent's Signature

Physician/Legal Prescriber's Signature: _____
Name (please print): _____
Address:_____
Telephone: _____ Date of Request: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I request the designated school personnel to assist my child in the administration of the above prescribed medication. I give permission for my child to take this medication at school. I understand that (1) there is no liability on the part of Lafayette Christian Academy, its personnel, or agents for civil damages as a result of the administration of this medication to my child when the person administering the medication as an ordinarily reasonably prudent person would have acted under the same or similar circumstance; (2) this medication should be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first.

Parent/Guardian Signature: _____ Date: _____
Address: _____ Home Phone: _____
_____ Work Phone: _____

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication, or any change in medication requires a new form.