LAKE LURE
Classical Academy
A Challenge Foundation Academy

Mailing Address
PO Box 6
Lake Lure, NC 28746

Medication Form
Prescription and Over-the-Counter

Student _____ Date of Birth _____
Allergies_____
Medication _____ Dosage _____
(No injection will be given except in extreme emergency, such as allergy)
Time of medication administration: a.m. ____ p.m. ____
To be given from (date) _____
____ School to administer medication

____ If prescription is for EPI-PEN, INHALER or INSULIN student may self-carry and self-administer the medicine. I have provided education and he/she is knowledgeable and has demonstrated the necessary skill level for this medication.

Special instructions or possible adverse reactions:
_____

_____ _____ _____
Physician's Signature Date Telephone Number

Parent's Permission

I hereby give my permission for my child (named above) to receive medication during school hours. A licensed physician has prescribed this medication (if prescription).
I hereby release the School Board, their agents and employees from all liability that may result from from my child taking the prescribed medication.
I will furnish this medication in a container properly labeled by a pharmacist with identifying information (i.e. name of child, medication dispensed, dosage prescribed, and the time it is to be given.) Over the counter medication in the original container.

_____ _____ _____
Parent/Guardian Signature Date Telephone Number