LINCOLN SCHOOL
KATHMANDU, NEPAL

AUTHORIZATION FOR USE OF MEDICATIONS AT SCHOOL

Date: mm___ / dd___ / yyyy____

The following section is to be completed by the PARENT/GUARDIAN *(Please print)*

Name of Student: _____ Sex: M / F *(circle)*
Last *First* *Middle*

Date of Birth: ____/____/_____ Grade: _____
mm / dd / yyyy

Health Care Provider's Name: _____ Location: _____ Phone: _____

Please check the box that applies:

- ☐ I request that the authorized person at school assist my child in taking the medicine(s) described below.
- ☐ I request that my child be permitted to medicate himself/herself at school.

I also give my permission for the exchange of information between the school staff and the health care provider listed above. I understand that the medication is to be furnished by me in the original container, labeled with the name, strength and expiration date of the medication.

If the parent/guardian elects to authorize the student to medicate himself/herself at school, the parents/guardians shall hold harmless and indemnify the Lincoln School and the school's officers, employees and agents against all claims, judgements or liabilities arising out of the self-administration and carrying of medication by the above mentioned child.

Parent signature: _____ Date: _____
Parent name: _____

The following section is to be completed by the HEALTH CARE PROVIDER *(Please print)*

Diagnosis for which medication is given: _____
Name of the medication: _____ Dose: _____
☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Other _____
If medication is to be given **DAILY**, at what time? _____
If medication is to be given **WHEN NEEDED**, describe indications: _____
_____
How soon can it be repeated? _____
Is the child authorized to medicate himself/herself? ☐ **Yes** ☐ **No**
If **Yes**, I have instructed the student in the purpose and appropriate method or frequency of use; and student demonstrates necessary skill to use this medication and to use any device necessary to administer medication.
List significant side effects: _____
Length of time this treatment is recommended: _____
Other information: _____
_____

Health Care Provider's signature: _____ Date: _____
Health Care Provider's name: _____