Living Rock Academy

If your child takes long term medication, have this form filled out by your physician, and submit it with your student's completed enrollment packet.

PERMISSION TO RECEIVE LONG TERM MEDICATION

Must be completed by a Physician

Name of Student: _____ Date of Birth: _____

Name of Medication: _____

Specific Time(s) and Dose(s) to be given at school _____

Length of Time (Beginning Date) _____ (Ending Date) _____

Side Effects: _____

Is this condition contagious? ____ Yes ____ No

Are there any restrictions for the student while taking this medication? ____ Yes ____ No

If yes, what and how long: _____

Asthma, Anaphylaxis and Diabetes medication only - Secondary student is permitted to carry and self-medicate? ____ Yes ____ No

Name of Physician: _____ Phone: _____

Signature of Physician: _____ Date: _____

To be completed by student:

I, _____, will use my asthma, anaphylaxis and diabetes medication appropriately and not share it with others.

Student's Signature: _____ Date: _____

To be completed by parent:

I, _____, give permission for my child to receive the above referenced medication as directed while at school or with Living Rock Academy faculty and/or staff and/or carry and self-medicate while at Living Rock Academy (Secondary students only with asthma, anaphylaxis and diabetes medication).

Parent's Signature: _____ Date: _____

Phone: _____