LICK CREEK CCSD #16

2026 - 2027 MEDICATION AUTHORIZATION FORM

(RETURN THIS FORM TO SCHOOL)

Student's Name _____ Birth Date_____

Address _____

Home Phone _____ Secondary Phone _____

Grade _____ Teacher _____

Section below to be completed by the student's physician, physician assistant, or advanced practice nurse:

Physician's Printed Name _____
Office Address_____ Office Phone_____
Medication Name_____
Purpose_____
Dosage_____ Frequency_____
Time medication is to be administered at school or under what circumstances_____
_____
Diagnosis requiring medication_____
Is it necessary for this medication to be administered during the school day?____YES ____NO
Expected side effects, if Any_____
Time interval for re-evaluation_____
Other medications student is taking_____

_____
Physician Signature Date

For Parents/Guardians
By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency I hereby authorize Lick Creek CCSD #16 and its employees and agents, on my behalf, to administer or to attempt to administer to my child the lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices. I agree to indemnify and hold harmless Lick Creek CCSD #16 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of the medication to my child.

Parent/Guardian Printed Name _____ Date _____

Parent/Guardian Signature _____

LICK CREEK CCSD #16

2026 - 2027 MEDICATION AUTHORIZATION FORM

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Student Name_____
Last First Middle

Birth Date_____ Age_____ Grade_____

Mother Contact #_____ Father Contact #_____

Child's Physician_____ Physician Phone_____

Insurance Carriers/Medicaid Identification Number_____

Seasonal Allergies____Yes ____No Medication Required_____

Other Allergies____Yes ____No If yes, explain reaction_____

Any other medical concerns or information the school should be aware of:____Asthma ____Seizures ____Diabetes ____Heart Conditions ____Migraines ____Frequent Strep Throat ____Frequent Ear Infections ____Hearing Problems ____Vision Problems ____No History of Medical Issues

Other_____

List any medications your child is taking regularly. Please include epipens and inhalers.

_____

_____

Does your child have any vision concerns or wears glasses ____Yes ____No

Contacts ____Yes ____No

I understand the nurse or/and staff are legally unable to give any medications including but not limited to Tylenol, Ibuprofen, Tums, Cough Drops etc. under any circumstances without the enclosed medication authorization signed by a provider. ____Yes ____No

By signing below, I give my permission for the school to obtain emergency medical treatment for my child in the event I cannot be reached.

_____
Parent Signature Date