Lincoln Intermediate Unit 12
Leadership • Expertise • Innovation

PHYSICIAN'S REPORT – MEDICATION

Name of Child: _____ Name of Medication: _____

Purpose of Medication: _____

Description of Medication: _____

Date and Duration of Prescription: _____

Dosage: _____ Time of Dosage: _____

Special Instructions, if any (pills crushed, with water, after meals, etc.) _____

Possible reactions or side effects: _____

Procedure to follow if reaction/side effects are observed: _____

Person to contact: _____ Phone Number: _____

Special Storage required (refrigeration, etc.) _____

_____
Signature of Physician

_____
Date

I hereby authorize the medication listed above to be administered to my child by the classroom teacher, school nurse, (or in certain emergency situation, the driver), if available. We do agree to hold the said employee harmless from any liability connected with the administration of medication and medically provided services at the times and in the manner set by the physician.

_____ _____
Parent(s) Signature Date

SE-901B
Updated: 8/2015

NCR: White: Transportation Coordinator Yellow: Teacher Pink: Bus Driver