# Lafayette Regional School

## Medication Information/Release Form 2018-2019

**STUDENT'S NAME:**_____ **GRADE:** ____ **DOB:** _____

## MEDICAL INFORMATION

Primary Physician:_____Phone #:_____

If your child has had any serious illness, surgery, hospitalization, and/or medical treatment, please explain:_____

## INSURANCE INFORMATION

Insurance Company:_____Policy#:_____

## ALLERGY

Please list all known medical/food allergies:_____

Other medical concerns:_____

## NON-PRESCRIPTION MEDICATION RELEASE

(PLEASE CHECK **ONE** BOX FOR EACH MEDICATION)

| Name Of Medication | Administer at Student Request | Administer AFTER call to parent | DO NOT Administer |
|---|---|---|---|
| Acetaminophen (Tylenol) | | | |
| Ibuprofen (Advil) | | | |
| Diphenhydramine (Benadryl) | | | |
| Antacid (Tums) | | | |
| Bug Spray | | | |
| Sun Screen (Parent Must Provide) | | | |

## CONTACT INFORMATION FOR MEDICATION(S)

1.Name:_____Phone:_____

2.Name:_____Phone:_____

## OTHER:

Have there been any changes in the family and/or at home that may effect your child's work at school:_____

I hereby authorize and request the exchange of immunization information verbally and/or in writing between Lafayette Regional School and my child's physician: _____(physician's name)

I authorize the school's representative to transport, request, and authorize treatment for my son/daughter in the event of an accidental injury or illness. I agree that I will not hold this individual liable while he/she is acting according to these directions.

Parent/Guardian Signature:_____Date: _____