Lincoln Public Schools

PRESCRIPTION AND NON-PRESCRIPTION MEDICATION AUTHORIZATION

MUSEUM OF SCIENCE 6TH GRADE FIELD TRIP

Student's Name: _____ DOB: _____

____A. I authorize the nurse to administer _____Tylenol _____Ibuprofen

____B. My child will require the following prescription or non-prescription medications.

1. **Medication:** _____Dosage: _____

Times of Administration: _____

Diagnosis: _____

2. **Medication:** _____Dosage: _____

Times of Administration: _____

Diagnosis: _____

3. **Medication: _____Dosage: _____**

Times of Administration: _____

Diagnosis: _____

I authorize the Lincoln School Nurse to administer the above medication(s) to my child according to state and school protocols.

_____

Parent Signature **Date**

_____

Health Care Provider Signature **Date**