MEDICATION ADMINISTRATION FORM

Student's Name: _____ Date of Birth: _____ Grade:_____

Clinic: _____

Clinic Address: _____ Clinic Telephone Number _____

Medication: _____

Dosage/Route: _____

Time/Frequency: _____

Reason for Medication: _____

Possible Side Effects: _____May Self Administer: Y _____ N_____

Check one: ___ Prescription or ___ Over-The-Counter Estimated Termination Date: _____

Physician signature required for prescription medications and over-the counter medications that are to be given at a dose not recommended "for age" on the bottle.

Physician's Signature: _____ Date: _____

Print Physician's Name: _____

Parental Request for Administration of Medication

To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.

1. I request that my child receive the above medication during school hours as specified on this form.
2. I will immediately notify the school of any change in the medication.
3. I give permission for prescription medications to be given by designated personnel as delegated by the school nurse.
4. I give permission for my child to self-administer over-the-counter medications with supervision.
5. I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication, medical condition or side effects of this medication.
6. I release all school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Work phone: _____ Cell Phone:_____

This form expires at the end of the school year or when the medication changes.