Medication Administration Form

If this form is properly completed and returned to the school office, the designated staff member may assist parents when their chosen physician has prescribed medication for the student. The medication will only be given if it is delivered to the office in the original bottle, labeled with the student's names, dosage, physician, pharmacy, and name of the drug.

Student Name: _____ DOB: _____Grade: _____

Medication: _____

_____

Statement of Physician

Medication: _____ Date of Prescription: _____

Physician's Name: _____ Phone #: _____

Allergies:_____

Dosage and Times of Administration: _____

Illness requiring medication: _____

Possible medication side effects: _____

Physician Signature: _____

Physician Address: _____

Statement of Parent/Guardian

The undersigned hereby releases and agrees to hold harmless and to indemnify the employees from any liability whatsoever occasioned by the administration or non-administration of the above instructions.

The undersigned also authorized the prescribing physician, named above, to discuss with the principal or school designee any matter regarding the medication to be administered.

Signature of Parent/Guardian: _____ Date: _____

Home #: _____ Cell#: _____ Wk #: _____