Medication Administration Form

If this form is properly completed and returned to the school principal, 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 principal or his/her designee in the original bottle, labeled with the student's name, dosage, physician, pharmacy, and name of the drug.

Student's Name _____ Birth Date _____

School _____ Grade _____

Statement of Physician

Medication _____ Date of Prescription _____

Physician's Name _____ Phone Number _____

Allergies _____

Dosage and Time(s) for Administration _____

Illness Requiring Medication _____

Possible Medication Side Effects _____

Physician's Signature _____

Physician's 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 his/her designee any matter regarding the medication to be administered.

_____ _____ _____

Signature of Parent/Guardian Home Phone Work Phone

_____ _____

E-mail Address Cell Phone

_____ Date