_____ SCHOOL

PRESCRIPTION MEDICATION ADMINISTRATION FORM
GRADES PREK-12

This form must be completed and returned to the school principal/designee or school nurse before medication is administered. Medication will only be given if it is registered with the principal/designee or school nurse. All prescription medication must be unexpired and labeled with the name of the official pharmacy, physician, student's name, and dosage instructions.

Child'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.

_____ _____

Print name of Parent/Guardian Signature of Parent/Guardian

_____ _____ _____

Home Phone Work Phone Cell Phone

Email Address

Date

I have seen the above-labeled medication and have a copy of this permission form.

Signature:

Principal/Designee or School Nurse

Print Name:

Date:

Principal/Designee or School Nurse