______________________ 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