Instructions for Administrating Medication

Student's Name: _____ DOB: _____ Grade:_____

Parent/Guardian's name: _____ Telephone #: _____

Parent/Guardian's name: _____ Telephone #: _____

To Parent or Guardian:

- If your child requires medication while at school, please complete the top portion of this form and sign below indicating your permission.
- Please indicate in the box below, the dosage and frequency of any medication your child will need to take while at school.

All medication to be given at school MUST be in original labeled container or it will not be administered.

I hereby authorize the designated school staff to supervise and/or dispense medication as instructed below until I notify you of a change in writing.

I agree to hold the designated person(s) harmless in any and all claims arising from the administration of this medication at school.

Rx Date	Exp Date	Medication	Purpose	Dose Form	Dose	Time Scheduled	Duration

Name of Doctor/Healthcare Provider: _____

Precautions, special instructions, possible adverse effects, comments:

_____

_____

Signature of Parent/Guardian: _____ Date: _____

SCHOOL USE ONLY

Received by: _____ Date received: _____

Rev. 07/11/2024