Medication Administration Release Form

(Prescription or Over-the-Counter)

Student's name:_____ Birthdate:_____

Grade:_____ Teacher:_____

Name of medication:_____

Purpose of medication:_____

Form of medication: Pill ____ Liquid _____ Topical_____ Inhaler_____ Other_____

Dosage to be taken:_____

Times(s) to be taken:_____

Potential side effects: _____

_____

Starting date:_____ Ending date:_____

Name of health care provider:_____

Phone number of health care provider: _____

I request the student above receive the medication as ordered by the physician or parent while in school and school related activities. This medication may be safely given by an unlicensed individual who has demonstrated competency in medication provision.
I understand it is my responsibility to furnish the medication in the **original** container or prescription bottle **appropriately labeled** by the pharmacy or physician stating name of medication, dosage and instructions.
I agree to communicate with my child's teacher/school staff regarding the effects of the stated medication. I also understand that the school may choose to seek emergency medical care for my child before contacting me regarding any adverse side effects from this medication.

_____ _____

Parent/guardian signature Date

For Office Use Only

Received: _____ Medication Returned to Parent:_____

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