



Medication Administration Form

TO BE COMPLETED BY PHYSICIAN

Student's Name: _____

Reason for medication: _____

Medication: _____ Dose: _____ Time: _____

Other times of the day this medication is given: _____

Dose: _____

If the morning dose is missed at home, may it be given at school at parent's request?

Yes No

Administration date: Begin: _____ End: _____

Possible Side effects: _____

This student is under my medical care and requires medication during school hours.

Physician's Stamp:

Date: _____

Physician's Signature _____

TO BE COMPLETED BY PARENT/GUARDIAN

As the parent/legal guardian of the student listed above, I authorize the school nurse to administer this medication during school hours as prescribed. I understand that all medication must be brought to school with the written prescription on the container. Over the counter drugs must be sent in their original container. No medication will be given without the written permission of the physician and the parent/legal guardian. Permission must be renewed each school year. I shall reclaim any unused medication by the last day of the school year or it will be disposed by the school nurse.

Parent/Legal Guardian Signature

Date