

**Medication Administration Form**

If this form is properly completed and returned to the school principal, the designated staff member may assist parents when their chosen physician has prescribed medication for the student. The medication will only be given if is delivered to the principal or his/her designee in the original bottle, labeled with the student's name, dosage, physician, pharmacy, and the name of the drug.

Student'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 Address \_\_\_\_\_

Physician's Signature \_\_\_\_\_

**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 he principal or his/her designee any matter regarding the medication to be administered.

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_