MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. **This includes ALL over the counter medication** e.g.Tylenol, Ibuprophen, Benadryl, cough syrup, etc.

Name of Child _____ Grade _____

Name of Medication _____

Dosage _____

Purpose _____

_____

_____ _____

Parent/Guardian Signature Date

****

TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date _____

Pharmacy _____ Phone _____

Name of Medication _____

Name of Physician _____ Phone _____

Of Tablets Received _____

****

PHYSICIAN'S ORDERS

Name of Patient _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

COMMENTS _____

_____

Doctor's Name (please print) **Doctor's Signature** **Date**