ADMINISTRATION OF MEDICATION REQUEST
(1 form per medication per student)

STUDENT NAME: _____ Date of Birth: _____
STUDENT NUMBER: _____ TEACHER: _____
SCHOOL: _____

For the safety of all students at our school, these guidelines should be followed:

1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over-the-counter, must be accompanied by **this form and brought to the school clinic by an adult.**
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. It is the responsibility of the parent/guardian to inform school of any changes and update medication forms. **Medications stored in envelopes, baggies, etc., will not be administered.**
   ALL MEDICATIONS NEED TO BE ADMINISTERED ACCORDING TO DIRECTIONS ON LABEL.
4. **Medications must be picked up at the end of the year, or the school will dispose of them.**

Name of Medication: _____ Expiration Date: _____

Reason Medication Given: _____

Amount to be Given: _____

Time(s) to be Given: _____

Possible Side Effects: _____

Special Instructions: _____

I, _____, grant permission for the principal or designee to assist in administration of medication listed above for my child, _____, while at school, or when on field trips.

I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Home: _____Work: _____ Cell: _____

_____ _____
Signature of Parent Date

FOR CLINIC USE: ☐ Medication disposed of By _____ Date _____
☐ Medication picked up By_____Date_____
(parent signature)

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