SCHOOL HEALTH PROGRAM
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)*

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TO BE FILLED IN BY SCHOOL NURSE

*Prescription #*_____ *Date*_____

*Pharmacy*_____ *Phone #*_____ *Name of Medication*_____

*Name of Physician*_____ *Phone #*_____

*# Of Tablets Received*_____

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PHYSICIAN'S ORDERS

*Name of Patient*_____

*Name of Medication*_____

*Date of Prescription*_____

*Dosage*_____

*Purpose*_____

*COMMENTS*_____

_____

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