

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** _____