



DISPENSING OF MEDICATION DURING SCHOOL HOURS

School: _____ Teacher: _____

To be completed by physician:

Name of Student: _____ DOB _____

Medication: _____ Dosage: _____

Form of Medication to be given is circled below:

Tablet Ointment Capsule Inhalation Liquid

Other (Specify): _____

Purpose of Medication: _____

Time to be administered: _____ a.m. _____ p.m.

Possible side effects: _____

Contraindications: _____

Termination Date for Administering: _____

Physician's Signature

Date

Physician's Phone Number

To be completed by the Parent or Guardian:

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I assume full responsibility for informing the principal of any changes in my child's health or medication. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication. I will furnish this medication within a container properly labeled by a pharmacist with identifying information (e.g. name of child, medication dispensed, dosage prescribed, and the time to be given).

Signature of Parent or Guardian

Date

Parent or Guardian Phone Number

To be completed by School:

Name, Title, and initials of Person(s) to Administer Medication:

Approved by: _____
Signature of Principal

Date

Reviewed by: _____
Signature of School Nurse

Date