

## 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