

# STUDENT MEDICATION FORM

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

## EMERGENCY NUMBERS:

Parent/Guardian \_\_\_\_\_ Relative \_\_\_\_\_ Neighbor \_\_\_\_\_

Please Note:

It is required that the medication be brought to school in its original container or in an appropriately labeled container with the child's name clearly affixed to it. Parents need to bring medication to the office.

This form will become a part of your child's health record.

The undersigned releases and holds harmless \_\_\_\_\_ and its employees from all  
(School Name and Town)

claims that may arise as a result of action or inaction resulting from the request herein made. It is understood that the parent or guardian accepts full responsibility for the giving of medication. Medication, properly labeled, shall be placed in the hands of the School. Label must include: dosage, frequency, manner of application, and Doctor's name.

I hereby grant permission for the above named child to self-administer the medication described below.

\_\_\_\_\_  
Parent/Guardian Signature Date: \_\_\_\_\_

## To be completed by physician:

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time(s) of Administration: \_\_\_\_\_

Instructions for Administration: \_\_\_\_\_

Date of Prescription: \_\_\_\_\_ Termination for Self-administering: \_\_\_\_\_

Type of Disease or Illness: \_\_\_\_\_

Purpose of Medication: \_\_\_\_\_

Is this Medication necessary to maintain this child in school? \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Is this child receiving other medication? If Yes, Please List: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

## To be completed by School personnel:

The above medication was received and accepted for self-administering on \_\_\_\_\_ by \_\_\_\_\_  
(Date) (Signature)