WINDSOR LEARNING CENTER

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Director

# MEDICATION ADMINISTRATION FORM
## School Year 2021 - 2022

**INFORMATION TO BE COMPLETED BY PHYSICIAN:**

Name of Student:_____ DOB: _____

Date of Order: _____

Name of Medication:_____

Dose:_____

Time of Administration at School:_____

Diagnosis:_____

Physician Name and Phone Number: _____

Please use Physician's stamp here:

Physician's Signature _____

**PARENT PERMISSION SLIP**

I hereby give permission for my son/daughter_____ to be given the above medication in school and will assume any responsibility for any reaction that may occur.

_____ _____

Date Parent/Guardian Signature