SCHOOL YEAR: 2021-2022

MEDICATION ADMINISTRATION FORM

INFORMATION TO BE COMPLETED BY PHYSICIAN:

Name of Student: ______________________________DOB:_____________________

Date of Order: ____

Name of Medication: ____

Dose: ____

Time and Circumstances of Administration at School: ___________________________

Diagnosis: ____

Physician Name and Phone Number: ____

Please place 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.

______________________________ ______________________________

Parent Name (Printed) Parent's Signature

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Date