MEDICATION ADMINISTRATION FORM
School Year 2022-2023

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/Guardian Signature Date