MEDICATION ADMINISTRATION FORM

INFORMATION TO BE COMPLETED BY PHYSICIAN:

Name of Student: _____DOB:_____/_____/_____

Date of Order: _____ Valid for School Year: _____

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 Name (Printed) Parent/Guardian Signature

_____

Date