Phone: 704-237-5333 Fax: 704-973-9594

MEDICATION ADMINISTRATION FORM

TO BE COMPLETED AND SIGNED EACH YEAR BY PHYSICIAN/DESIGNEE AND PARENT

PRESCRIPTION MEDICATIONS

Absolutely no medications (non-prescription ,over the counter, or prescription) will be administered by either school personnel or self (student) without the written authorization of a physician/designee and parent. Dosages for all medications will be administered according to manufacturer's recommendations on the label unless otherwise indicated by physician. Please submit a new form during the school year if there are changes or additions. This form will also be the authorized form used for off campus activities, including overnight trips.

Student's name____ D.O.B. _______________ Grade _____________________

Drug Allergies (if none, state none) ____

I request that my child be administered the prescription medication (per school personnel or self**) as indicated in the physician's order below.

TO BE COMPLETED BY PHYSICIAN:

Please list any prescription medication which would need administering during school or school related activities (**whether administered by School Personnel or Self (Student).**

Name and form of medication Dosage___________________________________

Administration Time/frequency _______________________________________

Possible side effects: ____

Order in effect until (date):____

Physicia n Signature/ Date ____

Physician Address/Phone Number: _____________________________________

Student may self administer medications listed above: Yes: [ ] No: [ ]

TO BE COMPLETED BY THE SCHOOL: Date Received_____________________School Nurse ______________________

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PARENTAL PERMISSION / HOLD HARMLESS STATEMENT

I, the parent/guardian, authorize the school administrator or school nurse to direct members of the school staff to assist my child in taking the above medication(s) and agree that I will not hold liable any member of the school staff or an individual of official capacity who is directed by me (parent/guardian) and the school administrator or school nurse to assist my child in taking said medication.

Parent / Guardian Signature ____ Date ______________________