HEALTHY KIDS CLINIC
A Part of Cumberland Family Medical Center, Inc.

Healthy Kids Clinic
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Administration of Medication Form

Dear Guardians & Health Care Providers:

If your child requires medication during school hours, we **must** have this form completed and signed by the guardian **and** Health Care Provider prior to administering the medication. This form may be faxed to the school by the Health Care Provider or turned in by the Guardian. The duration of this form is for one (1) school year only.

SCHOOL YEAR _____

NAME: _____ DATE OF BIRTH: _____

GRADE: _____ ALLERGIES: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZIED PROVIDER

1. **Medication: _____ Dose: _____**
Directions: _____
Administration Time(s): _____ Route: _____
Diagnosis: _____ Duration Start: _____ Stop: _____

2. **Medication: _____ Dose: _____**
Directions: _____
Administration Time(s): _____ Route: _____
Diagnosis: _____ Duration Start: _____ Stop: _____

3. **Medication: _____ Dose: _____**
Directions: _____
Administration Time(s): _____ Route: _____
Diagnosis: _____ Duration Start: _____ Stop: _____

_____	_____	_____
Physician's Signature	Physician's Phone	Date
_____	_____	_____
Print Physician's Name	Physician's Address	FAX Number

*If the student is to self-administer or self-carry a medication a separate form must be filled out.
*This form must be filled out for all PRN and emergency medications as well unless orders written by provider on their form.
*Medication must be in original bottle and brought into school by guardian.

I give permission for the administration of the above medication(s) by trained school personnel according to standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication(s). I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the request for medication to be followed. My signature will give permission for exchange or verbal and written communication between Health Care Providers and School Nurses regarding my child's medical regime. I hereby authorize release of any needed information from the ordering physician regarding this medication.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Phone	Date