



## 2024-25 STUDENT MEDICATION RELEASE FORM

This form must be signed by a physician or nurse practitioner AND a parent/guardian for prescription medications. Only a parent signature is required for over the counter medications.  
All medication must be in the prescribed bottle or original package.

**Please print:**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student Grade \_\_\_\_\_

### PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL

**PERSONNEL: Check one:**

I have prescribed the following medication for this child and request school personnel administer the dosage given during school hours.

It is my professional opinion that this student is capable of carrying & self-administering the following medication:

Medication \_\_\_\_\_

Dosage and time of administration \_\_\_\_\_

Purpose or condition for which prescribed  
\_\_\_\_\_

**Check one:**

Daily

As needed (PRN)

**Signature of Health Care Provider:** \_\_\_\_\_ **Date** \_\_\_\_\_

Office Phone \_\_\_\_\_

### PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION:

**Check one:**

I request that the above medication be given to my child as prescribed by the physician. I understand I must provide this medication in the original bottle, properly labeled by the pharmacy with student's name, date, dosage, time and directions for administration. I release school personnel from any liability in relation to the administration of this medication at school.

I request and authorize my child to carry and/or self-administer their medication.

Parent/Guardian signature: \_\_\_\_\_ Date \_\_\_\_\_