



School Health Office
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Medication Administration Form 2025-2026

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time to be administered: \_\_\_\_\_ Dates to be Administered: \_\_\_\_\_

Condition for which medication is required: \_\_\_\_\_

Is this the INITIAL dose of a NEW medication for your child YES NO

Special instructions/Precautions/Side Effects of medication for your child:

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature (Required For Prescription Medication) \_\_\_\_\_

My signature below indicates that I request Argos Community Schools/Saint Joseph Health Systems Staff to administer the medication specified above to my child and I am giving Permission for Argos Community Schools/Saint Joseph Health System to contact the Physician for additional information, if needed.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number to be reached at: (\_\_\_\_\_) \_\_\_\_\_

Office use only

Table with 4 columns: Date, # Pills, Counter's Signature, and a row for Initial/Returned/Disposed.

Medication returned to: \_\_\_\_\_ Pills: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_