DAVIDSON COUNTY SCHOOLS MEDICATION FORM

Child's Name: _____ **DOB:** _____

School: _____

Parent/Guardian:
The administration of medication at school is discouraged. However, if medication must be taken while at school, authorization and specific instructions must be on file at school. All school administered medication must be sent to school in the original container and appropriately labeled. The parent/guardian is responsible for delivering the medication to school personnel.

Non-prescription medication – Parents/Guardians should complete Section A and Section C below and return this form to the school with the medication. All school administered medication must be sent to school in original containers with complete instructions.
Prescription medication – Parent/Guardian should complete Section B and Section C of this form. The prescribing physician must sign and date this form. The form must then be returned to school with the medication. All school administered medications must be sent to school in original containers and appropriately labeled containers.

Section A: Non-Prescription Medication

I request and give permission for the school to administer the listed medication to my child during school hours. I hereby release the School Board, and their agents and employees from any and all liability that may result from the administration of the medication. I understand the Medication Form must be correctly completed and medication must be brought to school in the original container with complete instructions.

_____
Signature of Parent/Guardian

_____ _____
Date Telephone Number

Medication (include Trade Name): _____

Form of Medication: (Circle) Pill/Tablet Liquid Topical Ointment
Describe color: _____

Dosage: Amount to administer: _____

Time to be given: _____

Relationship to meals: _____

Section B: Prescription Medication

I request and give permission for the school to administer the listed prescription medication to my child during school hours. I hereby release the School Board, its agents and employees from all liability that may result from the administration of the listed medication. I understand the Medication Form must be correctly completed including the prescribing physician's signature and must be brought to school in the original container and appropriately labeled by a pharmacist.

_____
Signature of Parent/Guardian

_____ _____
Date Telephone Number

Medication: _____
Include Trade Name and Prescription Number

Form of Medication: (Circle) Pill/Tablet Liquid Topical Ointment

Describe color: _____

Dosage: Amount to administer: _____

Time to be given: _____

Relationship to meals: _____

Side Effects: _____

Instructions should side effects occur: _____

_____

Contraindications for administration: _____

_____

_____
Physician's Signature

_____ _____
Telephone Number Date

Section C: Medical Release Information

I, parent/guardian, of _____

authorize my physician, _____

to release significant information regarding my child's health

care to the school for the _____ school year.

_____
Parent/Guardian Signature Date

Revised October 2014