Prescription Medication Release Form

Name of Student_____

School_____ Grade _____

Teacher_____

Medication_____ Dosage_____

Date Medication started_____

Time of day medication is to be given_____

_____ Date_____
Signature of Physician

_____

I hereby give my permission for_____ to take the above prescription at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

_____ Date_____
Signature of Parent/Guardian

Note: The medication is to be brought to school in the original container, appropriately labeled by the pharmacy or physician stating the name of the medication, the dose and the time to be administered.

Authorization for Medication(s) To Be Taken During School Hours

The following section is to be completed by the Parent:

School Name:_____

Child's Name:_____
Last First Sex Birth date

Physician's Name:_____

Physician's Address:_____

Physician's Phone Numer:_____

Emergency Contact Name and Number:_____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to self-medicate her/himself as also authorized by me and my physician (see below).

_____ _____ _____ _____
Date Parent/Guardian Signature Home Phone Work Phone

The following is to be completed by the PHYSICIAN:

DIAGNOSIS for which medication is given:_____

Name of Medication:_____ Form:_____ Dosage:_____
If medication is to be given **Daily**, at what time or in what situation:

_____

If medication is to be given as **"When Needed",** describe indications:

_____

How soon can it be repeated/under what conditions?

_____

Is child authorized to medicate himself/herself? Yes No
List significant side effects:

_____

_____

Length of time this treatment is recommended:_____
Other Information:

_____

_____

_____ Date_____
Physicians Signature