Medication Record

To be completed by physician for prescription medications. To be completed by parent/guardian for all non-prescription medications.

Name: ___________________________ School_________________

DOB: __________ Grade__________ Teacher_________________

Name of Medication: ______________________________________

Dose, Route, Time to Administer, How often per school day:

____

Start Date: _________________ End Date: ________________

Purpose of the Medication: ___________________________________

____

Possible Side Effects of this Medication: _______________________

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Allergies: ____

Does this medicine need to be carried by the student? __Yes __No

______________________________ ______________________

Physician's Signature Date

I authorize the principal and/or the designee to assist with self-administration of the medication to my child as stated above. I release the school personnel from any and all liabilities.

______________________________ ______________________

Parent Signature Date