Laurel Springs School

Medication Administration Permission
School Year _____-_____

Please complete a separate form for **EACH** medication.

Date: _____ Grade: _____

Child's name: _____

Medication: _____

Prescription: ___ Non-prescription: ___

Dosage: _____ Route: _____

Time to be given (or special circumstances under which medication shall be administered):
_____

Diagnosis: _____

May skip school-time dose on field trip: Yes__ No__

Possible side effects: _____

Prescription effective dates: From _____ To _____

We give our permission for the above medication to be administered by the School Nurse during the school year 20___-20____. It is my understanding that the School Nurse will administer the medication as specified above. We agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by us (the parents/legal guardian) to assist our child in taking the above medication. Any change to the above will occur ONLY with written instructions from the physician. **All medication must be brought to school by the parent/guardian in the original container with the pharmacy label.** If needed, your pharmacy should provide you with an extra labeled container. No envelopes or baggies please! If the medication is an over-the-counter medication, please label it clearly with the student's name.

Physician's Signature:_____ Date: _____

Parent's Signature: _____ Date: _____

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