**ADMINISTRATION OF MEDICATIONS**

Child’s Name: Homeroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medication:

Purpose of Medication:

Physicians requirement for dosage and method of administration:

What to do in case of side effects:

Termination date for administering medication:

 Date Physician Signature

Date Parent Signature\*\*\*\*

Date Approved by:

Student Signature

School Name Date

\*\*\*\*Parent permits medication administration as well as contact with the prescribing, physician if there are medication questions,