

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

****Parental signature permits medication administration as well as contact with the prescribing physician if there are medication questions.