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

_____ X _____
Date Parent Signature****

_____ _____
Date Student Signature
Approved by:

Warren Rd Elementary _____
School Name Date

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