



2009-2010 ADMINISTRATION OF PRESCRIPTION MEDICATION

Student Name _____ DOB _____ Grade _____

Check all that apply:

GLASSES _____ HEARING AID _____ EAR TUBES _____ OTHER (SPECIFY) _____

Health Problems: _____

P.E. Restrictions: (Physician's note required) _____

Routine Daily Medications TAKEN AT HOME:

Medication	Dose	Time	Symptoms of Medication

Routine Daily Medications TO BE GIVEN AT SCHOOL:

Medication	Dose	Time	Symptoms of Medication

Our policy requires this signed release from a parent or legal guardian before any medication may be given at school. **NOTE: The parent must also provide the medication in the original container with the name of the child on the prescription label. The parent or designated adult is required to transport all medication to and from school.**

Parent/Guardian Signature

Date

Physician Signature

Date