



## MEDICATION RELEASE FORM

**Note: Each medication requires a separate form.**

**This section to be completed by parent/guardian:**

Students' First & Last Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_

Form of medication/treatment: \_\_\_ Tablet/capsule \_\_\_ Liquid \_\_\_ Inhaler \_\_\_ Injection \_\_\_ Nebulizer \_\_\_ Other

Time(s) to be Given: \_\_\_\_\_ Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Potential Adverse Reactions: \_\_\_\_\_

State conditions which school personnel should administer medication (i.e. headache, fever, pain, cough, allergic reaction, etc.) \_\_\_\_\_

Students are not authorized to carry and/or self-administer any type of medication while on the school premises. Medications are held in the school office or by the homeroom teacher. Please specify where medication is to be held.

Circle one:            homeroom teacher            office

*I hereby give permission for school personnel to give this medication to my child according to the directions stated. No medication will be sent home with students. I agree to hold the school, its employees and agents, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.*

X \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Parent or Guardian Signature)

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Date: \_\_\_\_\_