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:_______________