

PHYSICIAN’S SCHOOL MEDICATION FORM

Name of School: _____

Name of Student: _____ Grade: _____ Age: _____

The above named person is a patient currently under my medical care. Due to a medical condition the medication listed below needs to be (given / taken / injected) during regular school day according to the following protocol:

Medication: _____ Dose: _____ Route: _____

Routine/Daily Medications: Time to be given _____ a.m. _____ p.m.

As needed medication for _____ Give every _____ hours.

Directions for administering medication: _____

If an emergency situation occurs during the school day, or if the pupil becomes ill, school officials are to:

a) Contact me at my office: _____

b) Take child immediately to the emergency room at: _____

c) Other option: _____

This medication will be properly labeled and will carry my name as the prescribing physician.

Date

Physician’s Signature

RELEASE OF LIABILITY FORM

I, _____ the parent and/or legal guardian of
_____ enrolled at

Name of Child

Name of School

Realizing the importance of administering medication to my child as prescribed by the child’s physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child’s physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing for the term of one year

Parent or Guardian’s Signature

Date

Principal’s Signature

Date

FOR SCHOOL USE ONLY

Date Physician School Medication Form Expires:

Please be reminded form will expire one (1) year from date of physician’s signature.