THE CENTER SCHOOL
CENTERING ON THE NEEDS OF OUR STUDENTS

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AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Student's Name_____ Age_____

Address_____

Diagnosis/Purpose_____

Medication _____Date _____

TIME MEDICATION IS TO BE GIVEN IN SCHOOL_____

POSSIBLE SIDE EFFECTS AND REMEDIAL ACTIONS REQUIRED_____

_____

TERMINATION DATE FOR THE USE OF THIS MEDICATION_____

All medication must be in the original container, labeled with a current date, dose, time, name of the medication and name of the student. If the prescription is changed, the school must have an updated version of this form signed by the physician.

PHYSICIANS SIGNATURE (required)_____

PHYSICIANS PHONE #_____

I understand the ultimate responsibility for administration of medication is mine and do hereby release, discharge and hold harmless the Center School, its agents and employees, from any and all liability and claim whatsoever for the administration of the above medication, pursuant to these directions.

In the event a school nurse is not present on a field trip, I agree to have my child's medication given (depending on the time of day):____Before trip departure ____After returning to school ____N/A

____I will be responsible for administering medication to my child at the given time. (Please choose one of the above.)

PARENT/GUARDIAN SIGNATURE_____ DATE_____