

Medication Dispensing Form

NOTE: MEDICATION BROUGHT TO SCHOOL MUST BE IN THE ORIGINAL CONTAINER.

Student's Name _____ Age _____ Grade _____

Reason for Medication _____

Medication/Dosage _____

Times to be Administered _____

Possible Side Effects _____

Effective Dates: From _____ To _____

Class Trip Days:

_____ Dose may be omitted.

_____ Schedule may be adjusted. (Please specify how) _____

Early Dismissal Days (1:30 P.M.):

_____ Omit afternoon dose.

_____ Maintain original schedule.

It is my understanding that the employees of the Delaware Township School charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment.

Physician's Signature

Date

Address

Telephone Number

As parent/guardian of the above named child, I hereby request the administration of the medication described above to my child and release the Delaware Township School District and its employees from liability for damages my child may suffer as a result of this request.

Parent Signature

Home and Work Numbers