



## MEDICAL RELEASE/ DISPENSATION OF MEDICATION FORM

- The school requires you to complete and return this form before any medication can be given to your child.
- The medication is to be in the original container with the original label.
- A new form must be completed if there is a change in the medication.

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(month/ day/ year)

Address: \_\_\_\_\_

Parents/Guardians: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Business Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Pharmacist: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Medication Request

Condition being treated: \_\_\_\_\_

Medication prescribed: \_\_\_\_\_

Dosage instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Possible side effects: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Special handling or storage requirements: \_\_\_\_\_

\_\_\_\_\_

In case of an adverse reaction, follow-up care and transportation are as follows: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other pertinent information \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Authorization**

I hereby request and authorize the administration of medication for my child as detailed above. I recognize the administration of medication will be handled by non-medically trained staff. I release school personnel from liability should reactions result from medications.

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Administrator's Signature: \_\_\_\_\_

Date: \_\_\_\_\_