

# Community School of Davidson

## AUTHORIZATION FORM to ADMINISTER MEDICATION

Name of student: \_\_\_\_\_

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

Time medication needs to be given: \_\_\_\_\_ a.m. \_\_\_\_\_ p.m.

To be given from (date): \_\_\_\_\_ to \_\_\_\_\_

Significant information (include side effects, toxic reactions, etc.): \_\_\_\_\_

\_\_\_\_\_

Contraindications for administration: \_\_\_\_\_

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

Contact the parent at: \_\_\_\_\_

Contact the physician's office at: \_\_\_\_\_

Take child immediately to the emergency room at: \_\_\_\_\_

This medication will be furnished by the parent or guardian within a properly labeled container by a pharmacist with identifying information, (name of child, medication dispensed, dosage prescribed, and the time to be given).

\_\_\_\_\_

Physician's Signature

\_\_\_\_\_

Date

## PARENT'S PERMISSION

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release Community School of Davidson and its employees from all liability that may result from my child taking the prescribed medication.

\_\_\_\_\_

Parent or Guardian Signature

\_\_\_\_\_

Date