

MEDICATION ADMINISTRATION FORM  
SOUTH SPENCER SCHOOL CORPORATION

The following form needs to be turned in to the school office if your child is to be given medication by school personnel during school hours. **A new permission form must accompany each new medication the student is to be given at school.**

I request that school staff members administer medication to my child during school hours in accordance with the instructions I have written below. (No dosage may be given beyond the recommended dosage for over the counter medications.):

Child's Name: \_\_\_\_\_

School Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Purpose of Administration: \_\_\_\_\_  
\_\_\_\_\_

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

Time or times of administration: \_\_\_\_\_

Termination date for administered medication: \_\_\_\_\_

Unusual side effects to watch for: \_\_\_\_\_  
\_\_\_\_\_

Any special instructions: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# AUTHORIZATION FOR MEDICATION/TREATMENT

To the Parent:

The following information is necessary for any student to possess or use prescribed medications or to receive treatment in school. **PLEASE COMPLETE ALL SPACES OR THE MEDICATION/TREATMENT WILL NOT BE ADMINISTERED.**

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
parent daytime phone #

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School

\_\_\_\_\_  
Room/ Teacher/ Grade

- I request permission for my child named above to: (Check all that apply)  
\_\_\_\_\_ use or receive treatment  
\_\_\_\_\_ self-administer medication in the presence of school personnel in accordance with the doctor's prescription.
- I will assume responsibility for safe delivery of the medication to school.
- I will pick up **ALL** medications for my child at the end of the school year as I understand the school is not allowed to send medication home with my child.
- **I understand that all medication left at the school at the end of the school year will be discarded by the school nurse if I do not pick it up by the last day of school.**
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the school board, school officials, and school employees harmless from and not responsible for any and all liability for damages or injury resulting directly or indirectly from this authorization.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Work Telephone