2015.1 –Medication Administration

Form in School or Child Care

NOTE: *fields marked with an * must be completed by a healthcare provider for prescription medication.*

Child Name: _____

Medication: _____

Time and Dosage given at school: _____

Any special instructions: _____

Reason for medication: _____

_____
(Completed by doctor if a prescription)

*** If prescribed by a Healthcare Provider**

*Start Date: _____ *End Date: _____

*Name of Physician: _____

*Signature of Physician: _____

_____ All medication must be in the original container. All prescription medication must contain the following information: students name, dosage, healthcare provider, pharmacy, date issued and prescription number.

At the conclusion of the school year, all medication must be picked up by parents from the office within one week of the end of the school year or medication will be disposed of by school personnel. (Medication will not be sent home with students).

Waiver of Liability
I understand that St. John's Academy will administer only the prescribed/over the counter medication mentioned above. I hereby waive all claims against the school and agree to hold the school harmless from any and all liability which may arise in connection with my child's use of medication.

Parent/Guardian's Signature _____ Date: _____