MEDICATION ADMINISTERED BY SCHOOL STAFF

IDENTIFICATION:
Child’s Name:_________________________________  Class:__________
Parent’s Name:______________________________  Phone:____________
Alternate Contact:___________________________  Phone:____________

DOCTOR’S INSTRUCTIONS:
Name of drug/medication:__________________________
Dosage Amount:_________________________ at (time)__________________
Name of Doctor:____________________________________
Additional Instructions:____________________________________

This authority remains valid ( ) for one week, or
( ) until________

Notes: Please read
1. The medication must be in the original container showing the chemist’s label with name, dosage, instructions, etc.
2. If a measuring cup or other equipment is needed, please supply it.
3. Except for Ventolin and its equivalents, all medication is kept in the school office.
4. Staff members are prepared to assist in this matter, but the ultimate responsibility rests with the parents.

Date:_________________________  Signature:_________________________