

MEDICATION ADMINISTRATION FORM

(To be completed by parent or guardian)

We are the parents or legal guardians of _____.
We request that medicine be administered to our child by a member of the school staff in accordance with our physician's instructions. We will notify the school immediately if we change physicians or if the medication or dosage is changed.

We agree to bring the medication to school in a container from a pharmacist properly labeled including name of the student, doctor, date, dosage, name of medication, and method of administration. Medication improperly labeled or contained, will not be administered at the school.

Parent's Signature _____

Address _____

Home Address _____

Business Phone _____

Date _____

To be filled out by school personnel

Director's Signature

Date

Athenian eAcademy
MEDICATION ADMINISTRATION FORM

To be completed by prescribing practitioner

Student's Name _____ Birth Date _____

Medication/dosage/method of administration _____
Reason for medication _____
Time to be administered _____
Anticipated number of days medication needs to be given at school _____
Possible side effects _____
Actions to be taken by school personnel _____
Expected effects on learning _____

Medication/dosage/method of administration _____
Reason for medication _____
Time to be administered _____
Anticipated number of days medication needs to be given at school _____
Possible side effects _____
Actions to be taken by school personnel _____
Expected effects on learning _____

Medication/dosage/method of administration _____
Reason for medication _____
Time to be administered _____
Anticipated number of days medication needs to be given at school _____
Possible side effects _____
Actions to be taken by school personnel _____
Expected effects on learning _____

The above named student is in need of the above named medication/drug during regular school hours or residential placement, to maintain his/her physical health. I advise and request:

- that non-medical school personnel be allowed to administer this medication/drug
- that said student be allowed to self-administer this medication/drug with the following instructions: _____

Practitioner's Name

Telephone

Date

Prescribing Practitioner's Signature

(COMPLETE BOTH SIDES)