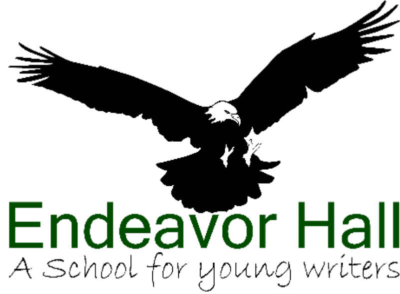

Medication Administration Release Form

I hereby certify that ___________________________has previously had at least on dose of the prescribed medications(s) listed below and did not have an adverse reaction from it. I request that this medication be administered as needed at school as prescribed by the physician. I understand that any school employee who administers this prescription to my child in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of adverse drug reaction suffered by the student, because of administering such a drug or because of a mislabeled or altered product. I hereby authorize endeavor Hall personnel to exchange information regarding dispensing and monitoring of this medication with ______________________, the attending physician or dentist, or with the pharmacy as identified on the label of the prescribed medication attending physician or dentist, or with the pharmacy as identified on the label of the prescribed medication container.

____
Signature of Parent/Guardian

____
Printed Name of Parent/Guardian

____
Date

NOTE: The medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the student, medication, dosage and times to be administered.

Teacher/Grade (2020-2021) _________________________

Student's name____________________________

	Medication #1	Medication #2	Medication #3
Dosage			
Special Instructions			
Time of dosage			

Physician's Signature: _______________________________________

Phone number: ______________________ Fax number:_______________________ Date:______________________