Medication Administration Instruction for Non-Prescription Medication

This form will need to be filled out each year and returned to the office at the beginning of the school year for your child to receive any non-prescription medications during school hours. **Auburndale School District has permission to give my child:**
Ibuprofen Liquid/Tablet _____Dose
Acetaminophen Liquid/Tablet _____Dose as needed throughout the school year.

- All medication must be supplied by parents
- **Medications must be in original labeled container or it will not be administered**.
- All medications must be labeled with the child's name by parent prior to bringing to school.

Student's Name_____DOB_____Grade_____
Parent/Guardian_____Phone_____

Name of Medication(s) Dosage
_____ _____

Medication Form: Tablet, Caplet, Chewable, Syrup, Ointment, Drops,Other_____
(Circle all that apply)

Reason: Headache, Stomachache, Pain, Sore Throat, Cough, Other_____
(Circle all that apply)

Time Given: As needed_____Other_____ **Frequency:** As needed_____Other_____

Duration: School year_____Other_____

Auburndale School District has permission to give my child: Ibuprofen Liquid/Tablet _____Dose
Or Acetaminophen Liquid/Tablet _____Dose as needed throughout the school year.

I hereby authorize the designated school staff to supervise and/or dispense medication as noted above or outlined by the above directions. I further agree to hold the designated person(s) harmless in any and all claims arising from the administering of the medication at school.

Parent/GuardianSignature_____Date_____

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End of Year **Send Home_____** **Pick Up_____**

Prescription Medication

This form or a form from your doctor must be filled out prior to the administration of prescription medicine(s) to your child during school hours for each school year.

- A medication prescribed by a doctor
- Medication must be in its original container with current pharmacy label, name, dose, route, frequency, and doctor name.
- If medication needs to be taken at home and at school, please have your pharmacy provide you with another container with the above information that can be kept at school.

Student's Name_____DOB_____Grade_____
Parent/Guardian_____Phone_____

I hereby authorize the designated school staff to supervise and/or dispense medication as instructed by the physician until such time as the physician or I notify you of a change in writing. I further agree to hold the designated person(s) harmless in any and all claims arising from the administration of this medication at school.

Parent/Guardian_____Date_____

End of Year: Send Home_____ Pick Up_____

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Physician use only

Your consent and written instructions are needed for medication(s) to be given at school. A new consent must be signed each year.

Medication	Route	Dose	Time	Carry on Self	Side Effects

Comments_____

Physician____ **Date**______________________