Medication Administration Form

Providence Day School

Parent or guardian and Physician signature required:

Student Name: _____ Date of Birth: _____

Parent Name: _____

Please list **all prescription medications** your child is taking at this time, please include those which may need to be administered at school **AND/OR** on school-sponsored off-campus trips:

Medication 1: _____ Route: _____
Start date: _____ End Date: _____
Dosage: _____ Time of Administration: _____
Reason for taking this medication: _____

Medication 2: _____ Route: _____
Start date: _____ End Date: _____
Dosage: _____ Time of Administration: _____
Reason for taking this medication: _____

Medication 3: _____ Route: _____
Start date: _____ End Date: _____
Dosage: _____ Time of Administration: _____
Reason for taking this medication: _____

Medication 4: _____ Route: _____
Start date: _____ End Date: _____
Dosage: _____ Time of Administration: _____
Reason for taking this medication: _____

All medication must be furnished by the parent or guardian in a pharmacy labeled container or in the purchased container, if non-prescription.

UPPER SCHOOL ONLY:

___ **YES** ___ **NO** My child is in **Upper School** and I give permission for him/her to self-administer this medication while on school sponsored off-campus trips.

I give permission for the school nurse, or designated school personnel while off-campus on a school related trip, to dispense the prescribed medication(s) listed above to my child.

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____