DAVIDSON COUNTY SCHOOLS MEDICATION FORM

Child's Name: ________________________________ DOB: _____________________

School: ____

Parent/Guardian:
The administration of medication at school is discouraged. However, if medication must be taken while at school, authorization and specific instructions must be on file at school. All school administered medication must be sent to school in the original container and appropriately labeled.

Non-prescription medication – Parents/Guardians should complete Section A and Section C below and return this form to the school with the medication. All school administered medication must be sent to school in original containers with complete instructions.
Prescription medication – Parent/Guardian should complete Section B and Section C of this form. The prescribing physician must sign and date this form. The form must then be returned to school with the medication. All school administered medications must be sent to school in original containers and appropriately labeled containers.

Section A: Non-Prescription Medication

I request and give permission for the school to administer the listed medication to my child during school hours. I hereby release the School Board, and their agents and employees from any and all liability that may result from the administration of the medication. I understand the Medication Form must be correctly completed and medication must be brought to school in the original container with complete instructions.

____
Signature of Parent/Guardian

____________________ ______________________
Date Telephone Number

Medication (include Trade Name): ______________________

Form of Medication: (Circle) Pill/Tablet Liquid Topical Ointment
Describe color: __________________________

Dosage: Amount to administer: _________________________

Time to be given: ____________________________________

Relationship to meals: ________________________________

Section C: Medical Release Information

I, parent/guardian, of _________________________________

authorize my physician, _______________________________

to release significant information regarding my child's health

care to the school for the ________________ school year.

____
Parent/Guardian Signature Date

Section B: Prescription Medication

I request and give permission for the school to administer the listed prescription medication to my child during school hours. I hereby release the School Board, its agents and employees from all liability that may result from the administration of the listed medication. I understand the Medication Form must be correctly completed including the prescribing physician's signature and must be brought to school in the original container and appropriately labeled by a pharmacist.

____
Signature of Parent/Guardian

____________________ ______________________
Date Telephone Number

Medication: ____
Include Trade Name and Prescription Number

Form of Medication: (Circle) Pill/Tablet Liquid Topical Ointment

Describe color: __________________________

Dosage: Amount to administer: ________________________

Time to be given: ___________________________________

Relationship to meals: _______________________________

Side Effects: _______________________________________

Instructions should side effects occur: ___________________

____

Contraindications for administration: ___________________

____

____
Physician's Signature

____________________ ____________________
Telephone Number Date