Allen Academy

Daily Medication Administration Request

2020/2021

Student's Name:___________________________ DOB:____________________________

Grade:____________________________________ Teacher:_________________________

Allergies:____

Date of Request:___________________________

Medication	Dose (ml,tsp,etc)	Time to be given	Reason why	Side Effects or Special Notes

I, the undersigned parent/guardian of _________________________________ request the above medication(s) be administered to my child as requested above by the school nurse. I also give permission to my child's teacher or administration to administer the same medication as prescribed above in the absence of the nurse and on field trips during the school year. This medication has been prescribed by a licensed physician. I hereby release Allen Academy and its employees from any and all liability that may result from my child taking the above medication(s).

Parent Signature: ____________________________________ Date: ____________________

Prescribing Physician: ________________________________ Phone #: _________________

***A properly labeled, original prescription bottle is required and will stand as physician signature.**

***Student must have taken at least one dose of this medication at home prior to administration at school.**