Boyne Falls Public School

Authorization for Medication Administration Prescription

Revised: 6-17-22

The following information is necessary for administration of PRESCRIPTION medications in school.

Student FULL Name: _____ Date: _____

Grade: _____ Date of Birth: _____ Student Age: _____

Medication Information

Name of Medication: _____

Purpose of Medication: _____

Please Check ONE: Prescription: _____ Over the Counter: _____

Dosage: _____ Frequency: _____

Time(s) of Administration: _____

Beginning Date: _____ Ending Date: _____

Notes About Medication (adverse reactions, precautions, etc.): _____

_____ _____

SIGNATURE of Attending Physician Date

_____ _____

PRINT Name of Attending Physician Telephone

- I am requesting my child be administered his ***PRESCRIBED*** medication at school by school personnel per the directions above.
- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent/Guardian Date

_____ _____

PRINT Name of Parent/Guardian DAYTIME Telephone