ALLEN ACADEMY

A COLLEGE PREPARATORY SCHOOL

"As Needed" Medication Administration Request

2015-2016

Student's Name: ____________________________ DOB: ____________________________

Grade: ____________________________________ Teacher: __________________________

Allergies: ____

Date of Request: ___________________________ Student weight: ____________________

Medication	Symptoms to give medication for	Dosage (tsp, ml, mg)	Time interval between doses	Special Instructions or precautions

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

Signature: ______________________________________ Date: _________________________

Physician's Name: _______________________________ Phone #: ______________________

***Please send all as needed medications in their original packaging either in prescription bottle as released from pharmacy or in original box and bottle if OTC.**

***Prescription medications appropriately labeled and in their original container will stand as physician signature.**