ALLEN ACADEMY

Daily Medication Administration Request
2017-2018

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 mediation(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.**