Wellington

Request for the administration of medication

A separate form must be completed for each medication

Physician Section

Student's Name: _____

The above student is under my care and should receive the following medication:

Name of Medication: _____

Dosage: _____

Route: _____

Times: _____

Date First Dose to be administered: _____

Date Last Dose to be administered: _____

Possible side effects to watch for and report to physician: _____

_____

Specific instructions for administration (including authorization for self-administration of asthma Inhalers, if appropriate:) _____

_____

_____

Specific instructions for storage: _____

_____

_____

Physician's Signature: _____

Physician's Name (Print): _____

Office Number: _____ Date: _____

For Office Use only:

I hereby certify that the above stated drug was received by me on _____ in what appeared to be the container in which it was dispensed by the prescribing physician or licensed pharmacist.

_____

Signature of Person Authorized to Administer Medication

Wellington

PLEASE TURN OVER

Request for the administration of medication

A separate form must be completed for each medication.

Student's Name: _____ Birth date: _____

School: _____ Grade _____

PARENT SECTION:

I hereby request and give my permission to the Wellington Summer Program office and their personnel to administer the medication prescribed in the Physician's Section on the reverse of this form to my child under the terms listed below:

1) I understand and accept that occasional extenuating circumstances and activities occurring during the school day may make it impossible to administer the medication on the recommended schedule.

2) I will deliver the medication in the original, labeled container from the doctor or pharmacist or assume responsibility for safe transport of the medication by my child to the Summer Program Office.

3) I will monitor my child's supply of medication and be responsible for providing additional medication as needed.

4) I will submit a new medication request form in a timely manner each time there is a change in the recommended dosage or time of administration.

5) I understand that medication not collected by me within thirty (30) days of the date of the last dose to be administered (as designated by the physician) will be discarded.

6) I release and agree to hold the Wellington Summer Program personnel and employees harmless from any and all liability for damages or injury resulting directly or indirectly from this information.

Parent/Guardian Signature _____ Date_____

Print Name _____ Home Phone_____

Address _____ Work Phone _____

City/State/Zip _____