Richland School District Medication Administration Form

Student's Name: _____ Birth date: _____

Daily Medication

Medication/Dosage	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.				
2.				

As Needed (PRN) Medication

Medication/Dosage	Frequency	Start Date	Stop Date	Considerations/Side Effects
1.				
2.				

Other permitted medications provided by school:

☐ **Tylenol (pill or chewable)**

☐ **Ibuprofen**

☐ **Cough Drop**

***If box checked, medication will be administered per student need and per manufacturer's recommendations based on age and weight.**

- **I hereby grant permission for my child to take medication at school and authorize school personnel to contact my child's physician as necessary.**
- **I agree to provide the school with the medication in its original, properly labeled container.**
- **I agree to notify the school in writing when any change in medication is necessary, or at the termination of this request.**
- **I agree to release the school district, in which my child attends school, from any and all liability claims arising from the administration of this medication at school.**

****Parent Signature: _____ Date: _____**

(Needed for all medications)

MEDICAL PROVIDERS—ASTHMA INHALERS ONLY

☐ I have instructed this student in the proper way to use his/her inhaled asthma medication. It is my professional opinion that this student should be allowed to carry and use his/her inhaled asthma medication by him/her.

Print Medical Provider Name: _____ Date: _____

Medical Provider Signature: _____

(Needed for prescription medications)