West Bloomfield Schools

Medication Administration Form

Student's Name: _____ Date of Birth _____

Parent(s): _____ Cell number _____

School Year: _____

Medication #1 _____ Dosage: _____

Medication type (circle) Daily Emergency As Needed

Form of medication (circle) Pill/Capsule Liquid Inhaler Injection Topical Drops

Time to be given at school: _____ If PRN, allowable frequency: _____

Side effects of medication: _____

Medication #2 _____ Dosage: _____

Medication type (circle) Daily Emergency As Needed

Form of medication (circle) Pill/Capsule Liquid Inhaler Injection Topical Drops

Time to be given at school: _____ If PRN, allowable frequency: _____

Side effects of medication: _____

Medication #3 _____ Dosage: _____

Medication type (circle) Daily Emergency As Needed

Form of medication (circle) Pill/Capsule Liquid Inhaler Injection Topical Drops

Time to be given at school: _____ If PRN, allowable frequency: _____

Side effects of medication: _____

I hereby request that my child receive medication during school hours per the physician's order and the West Bloomfield Schools medication policy. I will not hold the West Bloomfield Board of Education or its personnel responsible for complications related to the medication. Permission to administer medication expires at the end of the school year.

_____

Parent/Guardian Name (print) Signature Date

Physician's Name (Print) Physician's Signature Date

Office phone number _____

Office Address _____