Willow Oak Montessori
A Public Charter School

REQUEST FOR MEDICATION ADMINISTRATION IN SCHOOL

School Year_____

To Be Completed by Physician if a Prescription or Over-the-Counter Medication

Name of Student: _____DOB_____

Medication (separate form for each one): _____

Dosage: _____

Time(s) to be Given: _____

Date(s) to be Given: _____

Significant Drug Information/Contraindications for Administration: _____

_____

Physician's Name and Phone Number: _____

Parent(s) Name(s) and Phone Numbers: _____

Physician's Signature: _____ Date: _____

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication according to the terms stated above.

I will furnish all medication for use at school in a container properly labeled by a pharmacist with identifying information (name of child, name of medication, dosage prescribed and the time to be given).

Parent/Guardian Signature: _____ Date: _____