PHYSICIAN'S SCHOOL MEDICATION FORM

Name of School		
Name of Student	Grade	Age
The above-named person is a patient currently under my medilisted below needs to be (given/take/injected) during regular s		
Medication:Dos	e:	Route:
Routine/Daily Medications: Time to be given	am	_pm
As needed medication for	Give every	hours
Directions for administering medication:		
If an emergency occurs during the school day, or if the pupil b	becomes ill, school	officials are to:
 a) Contact me at my office: b) Take child immediately to the emergency c) Other option This medication will be properly labeled and will carry my na	room at	
This inedication will be properly labeled and will early my ha	me as the presenting	ng physician.
DatePhysician's Signatur	e	
RELEASE OF LIABILITY FORM		
I,		ent and/or legal guardian of
Name of Child	enrolled at <u>Free</u>	edom Christian Academy
Realizing the importance of administering medication to my chereby agree to relieve designated school personnel of any lia injecting or giving my child medication prescribed by the chil and/or legal counsel (lawyer) and realize its ramifications and statements. I consent for the medial provider to disclose health prescribed. I understand that I may revoke this consent at any reliance on it. This consent is valid until I revoke it in writing	bility from any poted is physician. I have thoroughly underson or medical informatime, expect to the	ential ill effects as a result of their re discussed this with my physician tand the meanings of these lation regarding medication extent action has been take in
Parent or Guardian's Signature		Date
Principal's Signature		Date
FOR SCHOOL USE	EONLY	
Date Physician School Medication Form Expires:		
Please be reminded form will expire one (1) y	ear from date of ph	ysician's signature.