



Summit Academy Medication Administration Form

PHYSICIAN'S ORDER

Student's name: _____ Grade: _____

Date of birth: _____ Room Color: _____

Condition for which drug is being administered: _____

Medication: _____ Dosage: _____

Hours to be given at school: _____

For a period from _____ to _____
(date) (date)

Restrictions and/or side effects: _____

Additional comments: _____

Physician Name (Please print)

Physician Signature

Address and City

Telephone Number

PARENT/GUARDIAN AUTHORIZATION

I request that my child _____ receive the above medication at school according to school policy ordered above by his/her physician.

Parent/Guardian Signature

Date

Policy: Medication includes both prescription and non-prescription medicine. The proper form, which includes written permission from the parent/guardian must be filled out and returned to the office before medication can be dispersed. The form will also include written instructions. All medications will be administered by the Administrator, teacher, or other designated adult and in the presence of another adult. Medication must be brought into the office by the parent/ guardian. Medication must be in an original, labeled container.