ANTHONY WAYNE AND
CARE-A-LOT EARLY CHILHOOD CENTER
4932 Children's Home Bradford Rd.
Greenville, OH 45331

Phone: (937) 548-8323 Fax: (937) 548-8947

SCHOOL MEDICATION AND INSTRUCTIONS

PARENT/GUARDIAN PERMISSION Date: ______________________

Student's Name: ______________________________ Birth Date: ______________________________

Address: ____________________________________ City: ____________________________________

School: ____

Grade: _____________ Teacher: ____

I hereby request and grant permission for the above named school to supervise the medication routine below prescribed for the above named child. I hereby release the designated medication administrator, the above named school system and school board, the Principal of the school of which said child is the student, any supervisory personnel, their heirs, executors, administrators, or successors, from any and all liability that may arise out of services rendered in dispensing the below named medication. I further agree to submit a revised statement by the physician who prescribed this medication, if any of the information below changes.

____
Parent/Guardian signature

OVER THE COUNTER/NON-PRESCRIPTION DRUGS

Medications must be in the original medication containers

Medication (name, dosage, route)____

Reason for use: ____

Date to begin: ______________________________ Date to cease: __________________________________

Time or intervals dosage of drug is administered: ____

Special instructions and /or adverse affects: ____

____

__________________________________ ____
Physician signature if required Parent/Guardian signature

PRESCRIPTION DRUGS – PHYSICIAN'S DIRECTIONS

Medications must be in the original medication containers

Medication (name, dosage, route)____

Reason for use: ____

Date to begin: ___________________________ Date to cease: __________________________________

Time or intervals dosage of drug is administered: ____

Special instructions including sterile conditions and storage: ________________________________

____

Adverse effects to report (if any): ____

Telephone number(s) at which physician can be reached in emergency: ___________________________

Dr. requests the teacher's comments: ______ NO – teacher comments are not necessary

______ Yes – Please observe the following:_______________________________________

____
Physician's Signature