TRAFTON ACADEMY

Educating Minds, Building Character for Life.

Physician's Request for Administration of Medication at School

Date:_____ Birthdate:_____ Grade:_____

Name of Child: _____
Last First Middle

In order to keep this child in optimum health and to help maintain school performances, it is necessary that medication be given during school hours.

Form of medication to be given is circled below:

Tablet Capsule Liquid Inhalation Injection Other_____
(*no injection will be given except in extreme emergency)

Administration of medication is to BEGIN _____ and END on _____

Please list any and all medications, dosages, and times to be administered:

Medication_____ Dose _____ Time _____

Medication_____ Dose _____ Time _____

Medication_____ Dose _____ Time _____

Side effects which should be reported to the physician: _____

Special instructions for administration of medication: _____

_____ _____
Physician's Signature/Date Physician's Phone Number

This is your permission to give medication to my child named above as requested by the physician. I understand that Trafton Academy does not have any medically trained personnel on staff. I hereby release Trafton Academy, including all personnel from liability regarding the administration of the above medication.

_____ _____
Parent's Signature/Date Parent's Phone Number

Note: There must be written notification to school employees if any information provided by the physician changes. All medication must be delivered to the school by a parent in the container in which it was dispensed by the prescribing physician or pharmacist. Students are not permitted to carry medication on campus.