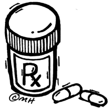

Clementon School Health Services

MEDICATION DISPENSING FORM

Date: ________________

Student Name: ______________________________ Date of Birth: ______________

The administration of medication by any student who has asthma or another potentially life –threatening illness will be permitted only when failure to take such medication would jeopardize the health of the student or the student would not be able to attend school or the school function if the medicine were not available. This student has been instructed in the proper use of the following medication procedures:

***To Be Completed By Physician**

Medication______________________________Dosage________________

Time(s)_________________________________Route_________________

If P.R.N., list indication for use:____________________________________

Possible significant side effects:____________________________________

Duration_____until further notice,____other____________________________

Are there any restrictions?____yes ____no if yes, describe___________________

Student___may, ___may not miss a dose of medication to attend a field trip or special activity.

Should the medication be given on early dismissal days? (____yes ____no

________________________	________________________	_________
Printed Name of Physician	Signature of Physician	Date

*** To Be Completed By Parent/ Guardian**

I, ___________________________________, give permission for my child to receive the above medication as directed by the physician. If my child may self medicate, I have attached the required "Indemnification/ Hold Harmless Agreement."

Parent/ Guardian
Signature:________________________________Date:______________________