



The Stonehaven School Medication Administration Form

Student's Name: _____

Teacher: _____ Grade: _____

I request that The Stonehaven School, through the principal or designee, supervise/assist in the administering of medication to my child according to the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies foil, etc.) Pharmacies can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide special instructions, as well as the medication and related equipment to the principal or school personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medications will be taken directly to the office by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

Name of medication: _____

Dose: _____ Route (by mouth, topical, etc.): _____

Time(s) to be given: _____ Stop medication on: _____

Physician's Name: _____ Physician's Phone: _____

I hereby authorize the school personnel, employees and officials of The Stonehaven School to assist my child in taking prescribed medication according to school policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

Parent/Legal Guardian *Date*

Home Phone _____ Work Phone _____ Cell Phone _____

To be completed by healthcare provider for prescription medications given for more than two weeks.

Condition/Illness Requiring Medication: _____

Possible Side Effects if any: _____

Signature of Healthcare Provider *Date*