Medication Administration Form
School Year 20__ - 20__

Riverbank Charter School Of Excellence
HOME ★ SCHOOL ★ COMMUNITY

Student Name _____DOB _____Grade_____

I request for the school nurse to administer the following medication to my child during school hours.

_____

This medication will be provided by me to the school in its original container labeled with my child's name.

I understand that the school nurse will be responsible for the administration and proper storage of the medication.

_____
Signature of Parent/Guardian **Date**

To be completed by Physician

I give consent for _____ to be administered the following medication:

Name of medication: _____

Dosage-in mg: _____

Reason for medication: _____

Time/days for administration: _____

Parameters-specific for PRN medications: _____

Potential side effects: _____

Start/stop date: _____

_____ **_____**
Signature of Physician **Printed Name of Physician**

Physician Phone Number: _____