Dayton Leadership Academies

Alliance Community Schools, Inc.
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Medication Administration Form

To Completed By Physician

Name: _____Date:_____

Date of Birth: _____Grade:_____

Diagnosis: _____

Medication: _____

Dose: _____ Frequency: _____

Start Date: _____ End Date: _____

Adverse Reactions: _____

Special Instructions: _____

Medication Allergies: _____

Other Medications: _____

Physician Address: _____

Phone Number: _____ Fax Number: _____

Physician Signature: _____

To Be Completed By Parent

I understand that the administration of said medication is to be done under the supervision of the Health Clinic Coordinator or an authorized member of the school staff. I further understand that the school personnel are not legally obligated to administer oral medication to any child and therefore, I agree to hold the school and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of there arrangements which may be rendered against them.

I agree to deliver the medication to the school in a container from the prescribing Physician or licensed Pharmacist with name of student, name of medication, dose and quantity.

I also grant permission for the Health Clinic Coordinator to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the Physician.

Parent Signature: _____Date:_____