Administration of Medication Form

FORT THOMAS INDEPENDENT SCHOOL DISTRICT

Robert D. Johnson Elementary
441-2444 fax: 572-4948

Ruth Moyer Elementary
441-1180 fax: 441-9440

Samuel Woodfill Elementary
441-0506 fax: 441-2755

Highlands Middle School
441-5222 fax: 441-4210

Highlands High School
781-5900 fax: 442-4221

Dear Parent or Guardian:

If your child requires medication, please try to schedule it before or after school hours, if possible. If the medication must be given during school hours, we must have this form completed and signed by you and your physician. Your doctor may fax this form to the school office.

TO BE COMPLETED BY PHYSICIAN:

Student's Name: _____ Date of Birth: _____

School Attending: _____ School Year: _____

Start Date: _____ Stop Date: _____

Name of Medication: _____

Reason for Medication: _____ Storage Requirements: _____

Recommended Dosage: _____ Time Administered: _____

Child's Allergies: _____

Reactions: Please list the potential reactions or side effects the child might have to this medication: _____

Student is capable/responsible for self-administration of:

FOR INHALERS/EPI-PENS: _____ and may carry this medication on his/her person. ☐ YES ☐ NO

FOR SCHOOL RELATED TRIPS (including overnight): _____ and may carry this medication on his/her person. ☐ YES ☐ NO

***Students are not allowed to self-administer or carry medication at school with the exception of emergency medication such as inhalers or epi-pens that has been physician and parent approved

Physician's Signature: _____ Date: _____

Physician's Address: _____ Phone: _____

TO BE COMPLETED BY PARENT OR GUARDIAN:

I give my permission for _____ to receive the above medication at school or on a school related trip according to standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed. I understand that school officials may need to contact the above named physician if additional information is needed. I hereby authorize release of any needed information from the above named physician regarding this medication. In case of a field trip, slight adaptations to the time of the medication administration may be necessary.

Parent/Guardian Signature: _____ Date _____

Home Phone: _____ Work Phone: _____ Emergency Phone: _____

TO BE COMPLETED BY SCHOOL PERSONNEL:

I/we acknowledge receipt of the foregoing Physician's Statement and Parent's Authorization.

Administrator/designee _____ Date: _____