

**Assumption Preschool
MEDICATION DISPENSING INSTRUCTION FORM**

To the Physician:

Schools in Pennsylvania may administer medication to a child only under orders of a physician. This applies to both prescription and over-the-counter drugs. Please complete this form if your patient should receive medication during school hours.

Student's name: _____ **Grade** _____

Medication Prescribed: _____

Prescribed dosage and frequency: _____

Time of day medication should be given: _____

Reason for medication: _____

Does medication require refrigeration?: _____

Precautions: _____

Side effects: _____

Is child taking any other medication(s)?: _____

Name of other medication(s): _____

It is my understanding that the employees of Assumption Preschool charged with the dispensing of medication may rely upon my directions on this form to dispense the medication which I have prescribed for:

Student's Name: _____

The authorization shall be in effect from _____, 20__ , to _____, 20__ .

I certify that I am the physician who prescribed the above medication and that the student who is to receive the medication is under my care. I further certify that it is imperative that the medication prescribed be taken during school hours.

Signature of Physician: _____ **Date:** _____

Print Name of Physician: _____

Address of Physician: _____

Phone Number of Physician: _____ **Emergency Number of Physician:** _____

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To the parent: **MEDICATION MUST BE SENT IN ITS ORIGINAL CONTAINER.**
I DO HEREBY RELEASE, DISCHARGE, AND HOLD HARMLESS Assumption Preschool, its agents, and employees from any and all liability and claim of whatsoever nature for the administration of the above medication to my child for any and all injury resulting there from.

Signature of Parent/Guardian: _____ **Date:** _____