



Administration of Medication While Under School Authority

LOWER AND MIDDLE SCHOOLS ONLY

This form is required for medications additional to those already detailed in the Student Health Information Booklet. This form is good for one school year.

Child's Name _____

Date _____

Name of Medication _____

Purpose of Medication _____

Method of Administration (Route) _____

Dosage (mg, ml, etc.) _____

Please be specific with dosage amounts; "1 tablet" or "per package directions" are not useful here

What time/how often medication is to be given _____

Dates to be given: From _____

To _____

Side Effects _____

Special Instructions, if any _____

Parent Request for school personnel to administer medication to student

I hereby request that my child _____ be given this medication as prescribed by

Dr. _____ in this order. It is understood that Hawken School and any of its school personnel are absolved from any responsibility which might be associated with the administration of such medication.

Parent's Signature

Phone Number

Date

Physician's Signature

Phone Number

Date