The Stonehaven School
Medication Administration Form

Student's Name: ____

Teacher: ____ Grade: ________________________

I request that The Stonehaven School, through the principal or designee, supervise/assist in the administering of medication to my child according to the instructions below. I understand that:

- Medications must be in the original labeled container (no baggies foil, etc.) Pharmacies can provide a duplicate labeled container with only the school doses.
- Parent/guardian must provide special instructions, as well as the medication and related equipment to the principal or school personnel.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medications or new doses will not be given unless a new form is completed and a newly labeled container is provided.
- All medications will be taken directly to the office by the parent/guardian.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of medication: ____

Dose: __________________________________ Route (by mouth, topical, etc.): _____________

Time(s) to be given: ______________________ Stop medication on: ________________________

Physician's Name: ________________________ Physician's Phone: _________________________

I hereby authorize the school personnel, employees and officials of The Stonehaven School to assist my child in taking prescribed medication according to school policy and I release them from any liability for administering this medication. I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

____ ____________________________

Parent/Legal Guardian *Date*

Home Phone ________________ Work Phone _________________ Cell Phone _________________________

To be completed by healthcare provider for prescription medications given for more than two weeks.

Condition/Illness Requiring Medication: ____

Possible Side Effects if any:____

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Signature of Healthcare Provider ***Date***