Lawrence School
Great Minds Don't Think Alike

NON - PRESCRIPTION MEDICATION ADMINISTRATION FORM

(ONE FORM PER MEDICATION)

ALL MEDICATION MUST BE IN THE *ORIGINAL* CONTAINER

DATE_____

SECTION I – STUDENT INFORMATION

Student Name_____

Date of Birth_____ Age_____ Current Grade_____

Parent Daytime Phone #_____

Known Allergies_____

SECTION II – MEDICATION DIRECTIONS

Name of Medication _____

Dosage _____

Medication is to be administered:

_____ As needed. May give every _____ hours

_____ Daily at _____am/pm (time)

_____ Weekly on _____ (day) at _____am/pm (time)

Date to Begin Medication_____ Date to End Medication_____

Special Instructions, if any_____

SECTION III – PARENT/GUARDIAN AUTHORIZATION

----Please regard my signature below as my assurance that I release Lawrence School, PSI, and any or all of the school's and PSI's officers and employees from any liability or damages resulting from the consequences of adverse reactions of our child taking or failing to take his or her medication at the times prescribed. I also agree to keep the school informed in writing of any revision to this medication administration request.

I also understand that **the medication must be provided to the school in the original bottle/packaging**.

Parent/Guardian's Printed Name_____

Parent/Guardian's Signature_____Date_____