

Students Name: _____

Medication Dispensation Form

Section 1 – Non Prescription

Please check the medications that you give permission for the school to dispense to your child. On the line behind the medication put the dosage, if it varies from the manufacturer's dosage.

- Acetaminophen(Tylenol)500mg . . . Dosage _____ (Mfr 2tabs/6 hrs)
- Ibuprofen 200m Dosage _____ (Mfr 1-2tabs/4-6 hrs)
- Benadryl Dosage _____ (Mfr 1-2tabs/4-6 hrs)
- Cough Drops Dosage _____ (Mfr 1drop/2 hrs)
- Tums Max. Strength. Dosage _____ (1-2 tabs/twice daily)
- None

Section 2 – Prescription – To be completed by Physician

I request and authorize the following medication _____ to be administered/provided to the above named student with the instructions indicated from _____ to _____. (Date is not to exceed the current school year)

If the medication is an epinephrine injector or inhaler, is the student to carry the medication on their person while in school and have they been instructed in the proper use of the medication? _____

Any additional instructions: _____

Provider's Signature _____

Phone Number _____

Date of Signature _____

I/we as parent/guardian of the above named student, request that Garden County Schools dispense the approved medication(s) listed above to my son/daughter as per the instructions outlined on this form in accordance with guidelines set for the medication(s). I/we also understand, that the primary accountability for monitoring all medications, their dispensation and their side effects remain our responsibility as parents, and I/we therefore release Garden County Schools and its employees from all liability relating to the dispensation of these medications to our son/daughter.

Parent's Signature _____ Date _____