ADMINISTRATION OF MEDICATION FORM

Hamilton Community Schools

Bentheim El. FAX: 269-751-7537, Blue Star El. FAX: 269-751-2901, Hamilton El. FAX: 269-751-7554, Sandyview El. FAX: 269-751-5089
Hamilton Middle FAX: 269-751-8560, Hamilton High FAX: 269-751-7670

Medications (both prescription and over-the-counter) may be administered at school by school personnel when necessary for school attendance. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

The prescription medication should be brought to school in the original container appropriately labeled by the pharmacy. Parents may request that the pharmacist dispense ***two*** bottles of medication, one for home and one for school. The non-prescription medication should be brought to school in the original unopened bottle. **No medication will be accepted in a plastic baggy.** Any medication left at school after June 30 will be disposed of.

Medication means: "any prescription or over-the-counter medication. This includes, but is not limited to: vitamins and food supplements; eye, ear and nose drops; inhalants; medicated ointments or lotions; aspirins; cough drops; antacids."

Student: _____ Birthdate: _____ School Year: _____

School: _____ Teacher: _____ Grade: _____

Parent/Guardian Name: _____ Phone Number: _____

Doctor's Name: _____ Dr. Phone Number: _____

Doctor's Address: _____

I, _____, _____ of
Parent/Guardian Name *Relationship*

_____, do hereby request that the building administrator or his/her designee,
Student

administer the (prescribed) medication listed below or procedure (listed below) as directed. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian: _____ Date: _____

To be completed by the Physician:

Reason/Condition for medication: _____

Name of Medication: _____

Form of Medication: ☐ tablet/capsule ☐ liquid ☐ inhaler ☐ injection ☐ nebulizer
☐ Other

Dosage: _____ Time ***during*** school: _____

Restrictions / and or side effects: ☐ none anticipated ☐ Yes

Please describe:_____

_____

Storage requirements: ☐ none ☐ refrigerate ☐ other

This student may transport his/her medication to school as needed: ☐ Yes ☐ No

This student is both capable and responsible for self-administering this medication: ☐ No ☐ Yes (supervised) ☐ Yes (unsupervised)

**Additional information: ☐ attached ☐ on back of form

_____ _____
Physician's name printed Physician's signature

Physician's Address: _____

Phone: _____ Fax: _____ Date: _____

This also authorizes an exchange of information, as necessary, between the school and my child's health provider.

A copy of this form will be kept in the student's CA-60 and office and will be renewed annually or whenever the prescription changes within the school year. 2008/09