TRI-CITY SCHOOL DISTRICT
MEDICAL RELEASE FORM FOR PRESCRIPTION MEDICATION

PLEASE SEND MEDICINE TO SCHOOL IN ORIGINAL CONTAINER

Child's Name ______________________________ D.O.B. ______________

(to be completed in full by physician)

MEDICATION ______________________ MG __________ DOSAGE ____________

FREQUENCY/TIME/ROUTE OF ADMINISTRATION ______________________

DATE OF PRESCRIPTION ______________ LENGTH OF TREATMENT ________

PHARMACY ______________________ PHONE ______________

ADDRESS ______________________

____

DIAGNOSIS REQUIRING MEDICATION ______________________

SIDE EFFECTS: ______________________________________

INTENDED EFFECT OF MEDICATION ______________________________

OTHER MEDICATIONS CHILD IS RECEIVING ______________________

TIME INTERVAL OF RE-EVALUATION ______________________

I hereby request, and give my permission for school personnel to administer the medication prescribed on this form to my child. When school nurse or administrator is not available, Superintendent's designee may give your child his/her medication. (The person signing this form is agreeing to hold the school and its personnel free from any or all suits which might arise from these arrangements).

____
parent signature

____
physician/dentist signature

____
address

____
address

____
home phone/cell phone

____
phone ER #

date ______________________

date ______________________