



Note: A Parent or Guardian must complete and sign this form.



**Medication Administration Form**  
Landmark Elementary Middle School  
Health Center  
Academic Year 2012-2013

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Medication: _____	Dosage: _____
Time given at home: _____	Time(s) to be given at school: _____
Prescribing Doctor's Name: _____	
Doctor's Address: _____	

Name of Medication: _____	Dosage: _____
Time given at home: _____	Time(s) to be given at school: _____
Prescribing Doctor's Name: _____	
Doctor's Address: _____	

Name of Medication: _____	Dosage: _____
Time given at home: _____	Time(s) to be given at school: _____
Prescribing Doctor's Name: _____	
Doctor's Address: _____	

Prescription Medication to be given in school requires a written doctor's order. Medication must be brought in or mailed in by an adult caregiver. Medications must be in the original labeled medication bottle. No more than a 30-day supply of the medication should be delivered to the school.

Student HAS\_\_\_ DOES NOT HAVE\_\_\_ my permission to be given prescription medication (including EpiPen) by Landmark School staff with a written doctor's order in school.

Student HAS\_\_\_ DOES NOT HAVE\_\_\_ my permission to receive over-the-counter medication from Landmark School staff including first aid topical treatments, pain, cold, cough, allergy, stomach upset relief medication, and EpiPen administration.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_