



EPISCOPAL
DAY SCHOOL

MEDICATION FORM

Pre-Kindergarten I – Sixth Grade

Permission for the administration of prescribed
and over-the-counter medication.

STUDENT: _____ AGE: _____
GRADE: _____ TEACHER: _____

All medications must be in original containers.

Over-the-Counter

Name of Medication:

Dosage/amount to be given:

Time(s) to be given:

Specific Instructions:

Prescription (*Must be in original container*)

Name of Medication: _____

Prescribing Doctor: _____

Doctor's Phone: _____

Dosage/Amount to be given: _____

Time(s) to be given: _____

Start Date: _____

Discontinue Date: _____

Refrigeration Required? Yes ___ No ___

Specific Instructions: _____

Is this medication for a life threatening condition?

Yes No

If this medication is for a life threatening condition, a *Medical Care Plan for Life Threatening Conditions* form must be completed, and you must discuss this with your child's teacher and the office staff before your child can attend school.

ALL MEDICATION MUST BE BROUGHT TO THE SCHOOL OFFICE – NOT THE CLASSROOM – IN THE ORIGINAL CONTAINER AND IN A ZIPLOCK BAG LABELED WITH THE CHILD'S NAME.

I grant permission for a school faculty or staff member to assist in the administration of the prescribed or over-the-counter medication for the above child. I understand this medication will be given according to the directions on the label. I agree the school will not be held liable for any illness or injury resulting from the administration of this medication.

Signature of Parent/Legal Guardian

Date