Kenowa Hills Public Schools
Education inspired.

Medication Administration Directions

Student _____ Date _____

Date of Birth _____ Grade _____

School: Central Elementary Phone: (616) 453-6351 Fax: (616) 453-9686

Name of Medication _____

Reason for Medication (optional) _____

Form of Medication

- ❏ Tablet/capsule
- ❏ Liquid
- ❏ Inhaler
- ❏ Nebulizer
- ❏ Injection
- ❏ Pump
- ❏ Other (Describe) _____

Dosage _____

Time _____

Special Instructions _____

I hereby request and authorize school personnel to administer my child's medication. School personnel may contact the office of my child's physician for concerns related to the administration of this medication. I understand that ***medication must be delivered to the school by an adult***, and that a new form must be completed for any change in medication.

Parent/Guardian Signature_____ Date _____

Phone Number _____ Alternate _____

Signature of Physician _____ Date _____

Print Name of Physician _____ Phone _____

A physician signature must be included for all medications, even those which are over the counter.