PRESCRIPTION MEDICATION ADMINISTRATION FORM
(PHYSICIAN'S SIGNATURE REQUIRED)

Student Name: _____ **D.O.B.**_____ **Grade:** _____

Address: _____

Parent/Guardian Name: _____ **Cell Phone:** _____

Diagnosis: _____

Name of medication/treatment: _____

Dose: _____

Time to be administered at school: _____

Method (route) of administration: _____

Medication to be administered from: _____ to _____
(Month/Day/Year) (Month/Day/Year)

Precautions and reactions to observe and report: _____

_____ _____ _____
Physician's Signature **Telephone** **Date**

_____ _____
PRINT Physician's Name **Clinic Name**

I authorize personnel at Breakaway Academy™ to administer the medication prescribed on this form to my child. I understand the medication must be provided in the original properly labeled container. I understand that the school and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing provider, the health specialist, and/or appointed staff to ensure safe medication administration for my child. I am responsible for picking up unused medication one week after the last dose is given during the school year, and/or before the last day of school. If the medication is not picked up, it will be destroyed.

Parent/Guardian Signature:_____ **Date:** _____

We encourage medication/treatment hours to be arranged outside of school hours, if possible.