ELIZABETH PUBLIC SCHOOLS

Medication Form

Student's Name: _____ ID#/School_____

Address: _____ D.O.B._____

_____	_____	_____
Parent/Guardian	**Home Telephone Number**	**Emergency Number**

To be completed by parent and/or legal guardian:

I request that my child be given medication at school by authorized school personnel and/or self-administer medication as authorized by my physician. I release school personnel from liability should a reaction result from said medication.

_____ _____

Signature of Parent/Guardian **Date**

I request that my child be given medication on the day of a school trip:

a. Prior to trip_____
b. Upon return from trip_____
c. Do not give day of trip_____

To be completed by Physician:

Diagnosis: _____

Medication: _____Dosage: _____

Procedure: _____Time of Day: _____

Length of time this treatment is prescribed: _____

Is child authorized and instructed to self-medicate and/or self-administer procedure? _____

Child should be given medication on the day of a school trip:

a. Prior to trip_____
b. Upon return from trip_____
c. Do not give day of trip_____

_____	_____	_____	_____
Physician's Signature	**Physician's Name (Print)**	**Date**	**Telephone Number**

Please stamp