



**Springer**  
School and Center

**Will your student take Medication @ School?**

No \_\_\_\_\_ (initial)       Yes

**If yes, please complete remainder of form.**

**FOR OFFICE USE ONLY – DISTRIBUTION:**

- School Office
- Main Office
- Homeroom: \_\_\_\_\_

**Prescription Medication at School**

**Parent/guardian Request for School Personnel to Administer Prescription Medicine**

It is our policy to keep in close contact with you and your physician on the monitoring of medication. The following information is necessary to comply with this policy. Written documentation from the physician is required for any change in type, dose, or timing of medication. It is the parent's/guardian's responsibility to provide the school with this documentation.

*Parents/Guardians should also inform the school in writing if a dose has been missed or if medication is discontinued.*

Please **answer all questions** and return this completed form to the SCHOOL OFFICE.

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

Street Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**TO BE COMPLETED BY THE STUDENT'S PHYSICIAN**

\*Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time/Frequency: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Please list and special instructions, side effects, or comments staff should be aware of: \_\_\_\_\_

Severe reactions that should be reported to the staff: \_\_\_\_\_

Special conditions for storage of drug: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone :** \_\_\_\_\_ **Fax:** \_\_\_\_\_

\*Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time/Frequency: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Please list and special instructions, side effects, or comments staff should be aware of: \_\_\_\_\_

Severe reactions that should be reported to the staff: \_\_\_\_\_

Special conditions for storage of drug: \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone :** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**TO BE COMPLETED BY THE STUDENT'S PARENTS/GUARDIANS**

The medicine must be in pill, capsule, liquid, auto-injector, or inhaler form; and must be clearly marked from the pharmacist. The label must show the student's name, medication name, number of pills, dosage directions, doctor, and prescription number.

Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

As the parent/guardian of this student, I give my consent to Springer School & Center and its staff to administer any prescription medication to my child, in accordance with the special instructions which I have given herein and I, on behalf of myself, my child, heirs, executors, administrators, assigns, as well as my child's guardian(s) and other parent, do hereby fully release and discharge the Springer School & Center, its trustees, assigns and successors, employees and agents from all claims of damages and actions whatsoever, including medical and emergency expenses, arising from the giving of such medication. **I further understand that parents/guardians are required to hand deliver the child's medication to the main office in the original prescription bottle and that medications will be stored in the school office. I also understand that Springer staff cannot release medication to a child to carry home on his or her person.**

**Name of Parent/Guardian (please print):** \_\_\_\_\_

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

**Primary Emergency Phone:** \_\_\_\_\_ **Secondary Emergency Phone:** \_\_\_\_\_