

Beauvoir Medication Form

Child's Name _____ Age: _____ Date of Birth: _____

Allergies: _____

This form must be thoroughly completed prior to the administration of medication(s). Medication(s) must be in the original container, prescription drugs must have the pharmacy label attached; all containers must be marked with the child's name, name of the drug, date, dosage, route and frequency of administration.

I release the school and its personnel of any liability related to the administration of medication(s) listed below:

Parent/Guardian Signature _____ Date _____

1. Prescription Drugs

Name of Medication _____

Dosage Amount _____

Route of Administration _____

Time(s) to be Given _____

Duration of Treatment _____

Diagnosis _____

2. Over-The Counter (OTC) Drugs

Name of Medication _____

Dosage Amount _____

Route of Administration _____

Time(s) to be Given _____

Reason for Use _____

Physician Signature _____ Date _____

Address _____

Phone _____

Additional Comments (need for refrigeration, must send home each day, etc.)

