Greater Amsterdam School District

Medication Administration Form

I give permission for my child, _____ (child's name), to receive _____ (medication) in school, as prescribed by the physician and to be given by school personnel.

_____ _____

(Parent/Guardian signature) (Date)

_____ _____

(Address) (Phone number)

Greater Amsterdam School District

Doctor's order slip for the Administration of Medication in School by School Personnel

Child's name _____ Child's DOB _____

A. Medication:
_____
_____

B. Dosage:
_____
_____

C. Observable symptoms indicating an emergency:
_____
_____

D. Duration of the order:
_____
_____

E. Diagnosis:
_____
_____

_____ _____

Doctor's signature Date

_____ _____

Doctor's Address Doctor's phone number