YORK COUNTY SCHOOL DIVISION

ADMINISTRATION OF MEDICATION FORM

We attempt to discourage the administration of medication during school hours; and, request, whenever possible, that medication be administered at home. We realize that this is not always possible; and will cooperate in the administering of medication when necessary.

PERMISSION TO ADMINISTER MEDICATION

I give permission for _____ to receive the medication prescribed by _____ .
Student Name Physician's Name

Name of Medication _____ Date/s to be given _____

Time to be given _____ Dosage _____

Reason for Medication _____

The medication should be in an appropriate container; labeled with the student's name, name of medication, amount and time to be given, and duration. PLEASE DO NOT SEND MEDICATION IN BAGGIES, KLEENEX, OR ALUMINUM FOIL.

_____ _____
Parent/Guardian Signature Daytime Phone Number

_____
Date

I request that the appropriate dose(s) of the above medication be sent on field trips to be given by my child's teacher or designated adult.

_____ _____
Parent/Guardian Signature Date

Form I-CL-4
Rev 6/03

York County School Division
Medication Card

Time: _____

Daily: _____ PRN: _____

Teacher: _____

Room No. _____ Grade: _____

Student's Name: _____ DOB: _____ School: _____

Name of Medication: _____ Dose/Route: _____

Special Instructions: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sept.																															
Oct.																															
Nov.																															
Dec.																															
Jan.																															
Feb.																															
Mar.																															
Apr.																															
May																															
June																															

Name/Position	Initials	Name/Position	Initials	Name/Position	Initials

CODES

A: Absent
ED: Early Dismissal
FT: Field Trip
N: None Available
R: Refused
X: Weekend/Holiday