HDS Medicine Release Form

New form to be completed daily unless authorized by the office. We cannot administer any medications without the form.

Complete form, printing clearly and in INK.

MEDICATIONS MUST BE PRE-MEASURED!!!!!

Child's Name: _____ DOB: _____ Date: _____

Child's Teacher: _____

Name of Medication: _____ Dosage: _____

Is this a prescription? Yes _____ No _____Refrigerate? Yes____ No____

Instructions:

_____

_____

If your child is sleeping, do you want us to wake them to give medicine? Yes _____ No ____

Time medication was last given *outside* of Day School: _____

Times administered during Day School hours:

____ AM PM Teacher administering medication: _____

Date:_____ Witness: _____

____ AM PM Teacher administering medication: _____

Date:_____ Witness: _____

____ AM PM Teacher administering medication: _____

Date:_____ Witness: _____

____ AM PM Teacher administering medication: _____

Date:_____ Witness: _____

____ AM PM Teacher administering medication: _____

Date:_____ Witness: _____

***Original**- home daily.* ***Copy**- student's office file.*