

# Wellington

## Request for the administration of medication

A separate form must be completed for each medication

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### Physician Section

Student's Name: \_\_\_\_\_

The above student is under my care and should receive the following medication:

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Route: \_\_\_\_\_

Times: \_\_\_\_\_

Date First Dose to be administered: \_\_\_\_\_

Date Last Dose to be administered: \_\_\_\_\_

Possible side effects to watch for and report to physician: \_\_\_\_\_

Specific instructions for administration (including authorization for self-administration of asthma Inhalers, if appropriate): \_\_\_\_\_

Specific instructions for storage: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Name (Print): \_\_\_\_\_

Office Number: \_\_\_\_\_ Date: \_\_\_\_\_

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For Office Use only:

I hereby certify that the above stated drug was received by me on \_\_\_\_\_  
in what appeared to be the container in which it was dispensed by the prescribing physician or licensed pharmacist.

\_\_\_\_\_  
Signature of Person Authorized to Administer Medication

**PLEASE TURN OVER**

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Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

School: \_\_\_\_\_ Grade \_\_\_\_\_

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### PARENT SECTION:

I hereby request and give my permission to the Wellington Summer Program office and their personnel to administer the medication prescribed in the Physician's Section on the reverse of this form to my child under the terms listed below:

- 1) I understand and accept that occasional extenuating circumstances and activities occurring during the school day may make it impossible to administer the medication on the recommended schedule.
- 2) I will deliver the medication in the original, labeled container from the doctor or pharmacist or assume responsibility for safe transport of the medication by my child to the Summer Program Office.
- 3) I will monitor my child's supply of medication and be responsible for providing additional medication as needed.
- 4) I will submit a new medication request form in a timely manner each time there is a change in the recommended dosage or time of administration.
- 5) I understand that medication not collected by me within thirty (30) days of the date of the last dose to be administered (as designated by the physician) will be discarded.
- 6) I release and agree to hold the Wellington Summer Program personnel and employees harmless from any and all liability for damages or injury resulting directly or indirectly from this information.

Parent/Guardian  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

City/State/Zip \_\_\_\_\_