FOR OFFICE USE ONLY – DISTRIBUTION:
☐ School Office
☐ Main Office
☐ Homeroom: ______________________

Prescription Medication at School – 2026-27

Parent/guardian Request for School Personnel to Administer Prescription Medicine
It is our policy to keep in close contact with you and your physician on the monitoring of medication. The following information is necessary to comply with this policy. Written documentation from the physician is required for any change in type, dose, or timing of medication. It is the parent's/guardian's responsibility to provide the school with this documentation.
Parents/Guardians should also inform the school in writing if a dose has been missed or if medication is discontinued.
Please **answer all questions** and return this completed form to the SCHOOL OFFICE.

Student Name:______________________________ Date of Birth:________________ Home Phone:________________________

Street Address:______________________________ Apt #_________ City:________________ State:_________ Zip:__________

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN

*Name of Medication:____ Dosage:_____________________

Time/Frequency:____Diagnosis:___________________

Please list and special instructions, side effects, or comments staff should be aware of: ______________________________
Severe reactions that should be reported to the staff: ____
Special conditions for storage of drug: ____

Physician's Signature:____ Date:_____________________
Physician's Name: __________________________________ Phone: _______________Fax:_________________

*Name of Medication:____ Dosage:_____________________

Time/Frequency:____Diagnosis:___________________

Please list and special instructions, side effects, or comments staff should be aware of: ______________________________
Severe reactions that should be reported to the staff: ____
Special conditions for storage of drug: ____

Physician's Signature:____ Date:_____________________
Physician's Name: Phone: Fax:

TO BE COMPLETED BY THE STUDENT'S PARENTS/GUARDIANS
The medicine must be in pill, capsule, liquid, auto-injector, or inhaler form; and must be clearly marked from the pharmacist. The label must show the student's name, medication name, number of pills, dosage directions, doctor, and prescription number.

Pharmacy: ____ Phone Number: ____________________________________
As the parent/guardian of this student, I give my consent to Springer School & Center and its staff to administer any prescription medication to my child, in accordance with the special instructions which I have given herein and I, on behalf of myself, my child, heirs, executors, administrators, assigns, as well as my child's guardian(s) and other parent, do hereby fully release and discharge the Springer School & Center, its trustees, assigns and successors, employees and agents from all claims of damages and actions whatsoever, including medical and emergency expenses, arising from the giving of such medication. **I further understand that parents/guardians are required to hand deliver the child's medication to the main office in the original prescription bottle and that medications will be stored in the school office. I also understand that Springer staff cannot release medication to a child to carry home on his or her person.**

Name of Parent/Guardian (please print): ____

Signature of Parent/Guardian: ____Date: _________

Primary Emergency Phone: __________________________________ Secondary Emergency Phone: ________________________

REV. June 2026 KRM ☐ Updated Database ____________________