



Request to Administer Medication

Name of Child: _____

Type of Medication: _____

Time to be Administered: _____ Quantity: _____

This medication is to be administered

_____ daily during the school year

_____ on the dates listed below only

Dates to administer medication:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has your child taken this medication before? _____

In case of suspected reaction or side effects, the school should contact:

_____ at Telephone number: _____

Does the school have your permission to send your child by ambulance to the closest hospital if an emergency reaction occurs? _____

The administration of medication is for the convenience of parents only. Tall Pines School is in no way responsible for the administration of the above named medication at a specified time. Parents are encouraged to phone the school at the appropriate time to ensure that the medication has been administered.

I, do hereby request that the above-named medication, in the quantity indicated, be administered to my child. I release Tall Pines School, its agents and employees from any liability for loss, damage or injury, however caused, to my child's person or property arising out of the administration or failure to administer the medication provided herein.

Signature of Parent: _____

Date: _____

Received for Tall Pines School by: _____