Bristol Township School District
School Medication Dispensing Form

Medication will be administered only when such medication is needed by the student to remain safely in school.
All medications both prescription and over the counter must stay in the health office. All prescription medication must **HAVE WRITTEN AUTHORIZATION FROM BOTH THE PARENT AND PHYSICIAN. NO MEDICATION WILL BE GIVEN WITHOUT COMPLETION OF THIS FORM.**
All medication must be in a properly labeled container.

TO BE COMPLETED BY PRIMARY CARE PROVIDER

Student Name _____ Date of Birth _____

School _____ Grade _____

Name of Medication _____

Diagnosis _____

Dosage: _____ Time to Administer _____

Duration: _____Daily
_____ PRN

Possible Side Effects of Medication _____

Special Considerations _____

It is my understanding that the employees of Bristol Township School District charged with the administration of this medication during the school day will rely on the directions contained in this document. I further certify that I am the primary care provider of the above named student.

Signature of Primary Care Provider: _____

Printed Name of PCP _____

Address: _____

Phone: _____ Fax: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

As parent/guardian of the above named student, I hereby request that the medication described above be administered to my child and release the Bristol Township School District and its employees from liability for any damages my child may suffer as a result of this request.

Signature of Parent/Guardian: _____Date: _____

Telephone (H) _____ (W) _____

Rev:6/10

(See reverse side for School District Medication Policy)