Medication Release Form 2024-2025

This form is to be completed and signed by the Parent/Guardian. If the medication is a prescription, SRL requires the signatures from both Parent/Guardian and the child's health care provider.

Student Name_____ Today's Date_____

Date of Birth_____Grade_____Allergies_____

I, the parent/guardian agree to deliver the medication to the school in its original container, with the pharmacy label affixed, including the child's name, the date the medication was prescribed and the name of the medication. In the case of over-the-counter medication, **I agree to deliver the medication to the school in its original container, with the child's name and homeroom on it.**

I authorize the school to assist my child in taking his / her medication; I agree that I will not hold liable the school, or any individual of official capacity who is directed by the School Administrator to assist my child in taking said medication. (Florida Statue 232.46 Administration of medication by school personnel)

Medication_____ Method of taking_____

Medication Expiration Date_____ Dosage_____

Given at (time)_____ Parent Name_____

Parent Signature_____ Parent Phone Number_____

Physicians Statement (for **Prescription** medication)

The above named child_____requires medication during the school day as follows:

Name of medication_____Dosage_____

Time_____Special instructions_____

This order is in effect until:_____

Date_____Physician Signature_____

Medication Administration Documentation on separate page.