

Healthy Kids Clinic A Part of Cumberland Family Medical Center, Inc. PO Box 2399 · Russell Springs, KY 42642 Toll Free: 844.435.0900 www.healthykidsclinics.com

Administration of Medication Form

Dear Guardians & Health Care Providers:

If your child requires medication during school hours, we **must** have this form completed and signed by the guardian **and** Health Care Provider prior to administering the medication. This form may be faxed to the school by the Health Care Provider or turned in by the Guardian. The duration of this form is for one (1) school year only.

SCI	HOOL YEAR		
NAME:	DATE	OF BIRTH	1:
GRADE: ALLERGIES:			
TO BE COMPLETE	ED BY PHYSICIAN OR AUTHOR	IZIED DD	OVIDER
	ED BY PHYSICIAN OR AUTHOR		OVIDER :
1. Wedication:			·
Directions:			
Administration Time(s):		Route	<u> </u>
Diagnosis:	Duration Start:		Stop:
2. Medication:		_ Dose:	:
Administration Time(s):		Route	:
Diagnosis:	Duration Start:		Stop:
3. Medication:		Dose:	
Directions:			 -
Administration Time(s):		Route:	
Diagnosis:	Duration Start:		Stop:
Physician's Signature	Physician's Phone		Date
Print Physician's Name	Physician's Address		FAX Number
*If the student is to self-administer or self-carr *This form must be filled out for all PRN and er *Medication must be in original bottle and bro	mergency medications as well unless		
give permission for the administration of the policy and expressly waive any liability on behaunderstand that I have the ultimate responsible request for medication to be followed. My sign petween Health Care Providers and School Numbeeded information from the ordering physicial	alf of the school as a result of adminis lity for providing the school with an a nature will give permission for exchan rses regarding my child's medical regi	stration of adequate s age or verb	the above medication(s). I upply of medication to enable the al and written communication
Parent/Guardian Signature	Parent/Guardian	Phone	 Date