PHYSICIAN'S SCHOOL MEDICATION FORM

Name of School: _____

Name of Student/Patient: _____ **Grade:** _____ **Age:** _____

The above named person is a patient of mine and is currently under my medical care. Because of the medical condition listed below, medication needs to be given (taken or injected) during the regular school day according to the following protocol:

Medication: _____

Time medication is to be administered: _____

Directions for administering medication: _____

_____

If an emergency situation occurs during the school day or if the pupil becomes ill, school officials are to:

a) **Contact me at: _KIDS FIRST PEDIATRICS OF RAEFORD 910-848-5437_____**
b) **Take child immediately to the emergency room at:** _____
c) **Other option:** _____

_____

The medication for this pupil from me will be properly labeled and will carry my name as the prescribing physician.

Date: _____ **Physician's Signature: _LEAMOR BUENASEDA, MD, FAAP_____**

RELEASE OF LIABILITY

I, _____, the parent and/or legal guardian of_____, enrolled at_____, realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their injecting or giving my child the medicines prescribed by my child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements.

Parent or Guardian's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____