SPECTRUM HIGH SCHOOL
ADMINISTRATION of MEDICATION at SCHOOL
(*Required areas)

Name of Student*: _____ Birthdate*: _____

School Year*: _____ Grade*: _____

Medications: Please fill out ALL information completely!

Medication *	Strength*	Dose*	Time*	Directions*	Possible Side Effects

Other considerations: _____

Start date*: _____ Stop date: _____ (All authorizations expire at the end of the school year)

_____ _____
Name of Physician/Licensed Prescriber* Telephone Number*

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) be given on field trips, as prescribed.
2. I release school personnel from liability in the event adverse reactions result from taking the medication(s).
3. I will notify Spectrum High School of any change in the medication(s), (i.e. dosage change, medication is discontinued, etc.).
4. I give permission for Spectrum High School Personnel to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition(s) being treated by the medication(s).
5. I give permission for the medication(s) to be given by designated school personnel as delegated by Spectrum Administration.

Please choose one plan in case there is unused medication*:

* **Plan A:** Please send the medication with my child on the last day of classes.
* **Plan B:** I will pick up my child's medication at school on or before the last day of classes. I understand that any medications remaining will be destroyed the week after classes let out for the year.

NOTE: Medication must be supplied in original/prescription bottle.

_____ _____
Parent/Guardian Signature* Relationship to Student *

_____ _____
Daytime Telephone Number* Date*