SCHOOL TIME LEARNING CENTER
MEDICATION RELEASE FORM

Child's Name ____ Date: ______________

This form is to be completed by the child's health care practitioner for any medication your child will need to be administered. Please complete one form per medication. Empty medication bottles will be returned to you for disposal.
Form MUST be signed by the child's health care practitioner – NO EXCEPTIONS.

Medication: ____ □ Prescription Medication
Condition for which prescribed: ____
Instructions for administering medication (**only if different from instructions on label**):
____
Note any possible side effects of this medication: ____
Remedy plan for side effects: ____
Note any reasons or conditions when this medication should be **stopped** or **not given**:
____
Length of time for which this medication is to be administered:

- From (date) ____________________ to (date) ________________________.

____ ____________________
Signature of Health Care Practitioner Date

____ ____________________
Printed or Typed Name of Health Care Practitioner Telephone Number

To be Completed by Parent/Guardian

I, the undersigned, give permission to the Director and designated staff to administer the specified medication to my child. I further agree to indemnify and hold their agents and servants harmless against all claims as a result of any and all acts performed under this authority.

____ ____________________
Signature of Parent/Guardian Date

To be Completed by School Time Staff (Fill in date, time and your name whenever dispensing medication.)

Day of Week	Date	Time	Dosage	Staff Initials

Disposition of Medication

Medication bottle returned to parents on ________________. Signed, ________________________

Please place this form in the child's file when medication is complete.