

## **Medication Authorization & Release**

Student				DOB	Grad	e			
Name of r	medication			Dosage					
Time(s) to	be taken		Ord	lering Physician_					
Reason fo	r medication_								
Parent/Gu	uardian			_ Phone number_					
Additional Emergency Contact				Phone	number				
were expe above me by the las	I certify that <i>at least one dose</i> of medication has <i>previously</i> been given and NO adverse reactions were experienced. Therefore, I give permission for the school nurse (or designee) to administer the above medication to my child and understand medication not picked up by the parent or guardian by the last day of school will be destroyed.  I acknowledge that eStem Public Charter Schools, its Board of Directors, and its employees shall be								
immune f	_					ication in accordar			
Parent/Gua	rdian Signatur	e			_Date				
						nt pharmacy label. The instructions on the lab			
			Initials	Medication Admin	istration Design	nee's Signature	$\Box$		
							$\exists$		
							$\exists$		
Data	Dill Count	Darant Sig	naturo	Nurso/De	neignoo	Commente			

Date	Pill Count	Parent Signature	Nurse/Designee Signature	Comments

## **Medication Administration Record**

STUDENT NAME	GRADE
MEDICATION	
DOSAGE	TIME

	AUG	SEPT	ОСТ	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
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