



DON GILL ELEMENTARY SCHOOL
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CHARLOTTE LAPPLA ELEMENTARY SCHOOL
32 MEADE STREET
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(570) 724-1941
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EVERY CHILD,
EVERY OPPORTUNITY, EVERY
DAY...
STRIVING FOR SUCCESS

MEDICATION INFORMATION FORM

Date: _____

Student's Name: _____ Grade: _____

Birthdate: _____

Name of Medication: _____ Dosage: _____

Purpose: _____

Time to be administered: _____

1. Possible Side Effects: _____

2. Procedure to follow if reaction occurs: _____

3. Curtailment of specific school activity (sports, shop, gym, drivers training, etc.) _____

4. Termination Date: _____

I hereby release the Wellsboro Area School District and all its employees from any and all damages my child may suffer as a result of this request. If the school nurse is not available, the principal or his designee will supervise the student's self-administration of the medication.

Parent's Signature

Physician's Signature

Date

Principal's Signature

School Nurse's Signature

Medication to be taken at school must be brought in by a parent or responsible adult in a labeled bottle from the pharmacy along with instructions and will be kept in the nurse's office.

Physician's signature is not necessary for non-prescription drugs such as aspirin, Tylenol, or cold medicine.