Transfiguration School

Consent and Release for Administration of Medication

I, __________________________ residing at ____
(Name of Parent/guardian) (Address)

parent/guardian of ____ Date of Birth ________________
(Name of Child)
hereby give permission to Transfiguration School to administer _____________________________.
(Name of Medication)
My child requires this medication because ____

and he/she will need this medicine for _______ days** or every ________hour(s) **or** emergency only.

The medication can be located: ____
(administrator's office/child's backpack)

It is prescribed by ____
(Name of Physician)
Physician's Address ____Telephone _______________

Best emergency Parent Contact Telephone ____________________________

Do you expect side effects of this medicine for your child? If so, explain _____

I authorize Transfiguration school staff to administer or assist my child with his/her medication when they deem it necessary.

Parent 1 Signature: ____ Date _____________

Parent 2 Signature: ____ Date _____________

***If your child requires scheduled medicine administration, the school must be given a doctor's prescription or note on the physician's letterhead. Medication cannot be administered without this documentation.*

Staff Use Only:

Date	Medication	Dose	Dates To be Given From-To	Date Given/Time	Staff Signature Title	Reactions