# WINDSOR LEARNING CENTER

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## MEDICATION ADMINISTRATION FORM

**INFORMATION TO BE COMPLETED BY PHYSICIAN:**

Name of Student:_____

Date of Order:_____

Name of Medication:_____

Dose:_____

Time and Circumstances of Administration at School:_____

Diagnosis:_____

Physician Name and Phone Number:_____

Please place Physician's stamp here:

_____ _____
Physician's Signature

**PARENT PERMISSION SLIP**

I hereby give permission for my son/daughter_____ to be given the above medication in school and will assume any responsibility for any reaction that may occur.

_____ _____
Date Parent/Guardian Signature