

Medication Release

Student's name: _____

Medication: _____

Dosage: _____

Dates to be administered: _____ OR

Circle if appropriate: as needed throughout the school year

Check all that apply:

- _____ use in emergency situations
- _____ use for headache
- _____ use for stomach upset
- _____ use for menstrual cramps
- _____ use for _____

Special instructions: _____

PLEASE NOTE: MEDICATIONS ARE GIVEN AT LUNCH TIME ONLY UNLESS IT IS AN EMERGENCY OR URGENT SITUATION.

I understand that only medication in the original container labeled with the child's first and last name will be given. I give permission for the staff at West Charleston Enrichment Academy to give my student medication according to the directions on this form.

Parent/guardian signature _____