FOR OFFICE USE ONLY:
Medication provided: ☐ Yes ☐ No
Expiration Date: _____

MEDICATION DISPENSING FORM

Please Note: Parents are responsible for providing Kinder Works with medicines, including EpiPens, that are within their effective dates; medicines must be replaced before their expiration dates.*

Student's Name _____ Age _____ Group _____

Name of Medication _____

Dosage _____ Frequency _____

Treatment or Procedure _____

Reason for Medication _____

Effective Date: From _____ 20_____ to _____ 20_____

It is my understanding that the employee of Kinder Works charged with the administration of medication may rely upon my directions as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment.

Signature: _____
Physician

_____
Address

_____
Phone

_____
Date

As parent/guardian of the above named child, I hereby request the administration of the medication described above to my child and release the Kinder Works staff from liability for damages my child may suffer as a result of this request.

Signature: _____
Parent/Guardian

_____
Home Phone

_____
Cell Phone

_____
Work Phone

NOTE: Medication brought to school must be in the original container.