UNIVERSITY SCHOOL
EAST TENNESSEE STATE UNIVERSITY

68 Martha Culp Drive, ETSU, Johnson City, TN 37614

Phone:(423) 439-4333 Fax:(423) 439-5921

MEDICATION ADMINISTRATION FORM

Please note: This form must be completed if your student requires administration of prescription, non-prescription, or other medications during the school day that are not provided by University School. If your student has more than one medication that will be administered at school, you and your healthcare provider must complete a separate form for each medication. Medication must be delivered by the Parent or Legal Guardian to school. All prescription medication must be delivered to the school in the original container. All non-prescription medicine must be delivered to the school in a new, unopened, manufacturer's container.

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN	
Student's Printed Name:	DOB:
Student's Current Grade:	
Parent/Legal Guardian Printed Name:	
Preferred Telephone Number:	
Alternate Telephone Number:	

By signing below, I authorize University School personnel to assist my student with self-administration of medication as indicated on this Medication Administration Form. Medication is administered solely at my request, and as an accommodation to me, the Parent/Legal Guardian. I assume full responsibility for any side effects and/or complications that my student may have resulting from these medications.

RELEASE: YOU HEREBY FULLY RELEASE AND DISCHARGE EAST TENNESSEE STATE UNIVERSITY, ITS OFFICERS, AGENTS, SERVANTS, AND EMPLOYEES; THE EAST TENNESSEE STATE UNIVERSITY BOARD OF TRUSTEES; AND THE STATE OF TENNESSEE, THEIR EMPLOYEES, OFFICERS, AND AGENTS FROM ANY AND ALL CLAIMS FROM INJURIES, DAMAGE, OR LOSS WHICH STUDENT MAY HAVE OR WHICH MAY ACCRUE TO STUDENT ARISING OUT OF THE ADMINISTRATION OR FAILURE TO ADMINISTER MEDICATION TO STUDENT.

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

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TO BE COMPLETED BY HEALTHCARE PROVIDER	
Name of Medication:	Dosage:
Diagnosis for which medication is given:	
Reason medication is needed at school:	
Start date:	Stop date:
Form (tablet, liquid, cream, etc.):	Route (oral, topical, inhaled, injected, etc.):
Special handling instructions: ☐ Refrigeration ☐ Keep Out of Sunlight ☐ Other: _____	
If medication is to be given daily, what time? _____ A.M. _____ P.M.	
If medication is to be given "as needed," describe the symptoms the student will exhibit:	
How soon can "as needed" medication be repeated?	
Possible side effects and procedures to follow:	

Healthcare Provider Printed Name: _____

Healthcare Provider Signature: _____ Date: _____

Address: _____

Telephone Number: _____

Fax Number: _____

SCHOOL STAFF USE ONLY

Completed form received by University School on: ____/____/20___

Form processed by: _____