# Alexsander Academy
# Medication Release Form

**Student Name: _____**

Does your child have medication that will need to be administered at school?
_____yes _____no
If yes, what is it? _____

If yes is checked please let us know if this is a prescription or over the counter medication_____

**Dosage**: _____
**Frequency**: _____
**Time of day**: _____
Any other information that we need to know: _____
_____
_____

If the medication is prescription your child's doctor must sign the form as well as the parent. For over the counter medication only the parent signature is needed.

I,_____, parent of _____ authorize the Staff at Alexsander Academy to administer the above medication per my instructions. It is my responsibility to submit in writing any changes to my child's medication regimen. The Staff will follow this authorization only until another is submitted in writing

_____ _____
**Doctor Signature** **Date** **Parent Signature** **Date**