



DEPARTMENT OF DEFENSE
FORT BRAGG SCHOOLS
PO BOX 70089
FORT BRAGG, NORTH CAROLINA 28307-0089
(910) 436-5410

Administration of Medication Request Form

Teacher _____

I request Fort Bragg School personnel administer medication to:

Student name: _____

Name of medication: _____

Amount/Dose to be given: _____

Time to be given: _____

For the treatment of: _____ As prescribed by Dr. _____

Amount supplied to school: _____

Special instructions, if any: _____

Discontinue end of current school year or on the following date: _____

The medication will be supplied in the correct medicine bottle with the pharmacy label. The label will have the child's correct name, the name of the medicine and the dosage.

I assume responsibility for any reaction or complication resulting from the administering of the above described medication and will not hold school personnel liable. I fully understand that the school personnel will administer medication only as requested on this form.

Signature of Parent or Legal Guardian _____ Date _____

Signature of School Official Accepting Medication _____ Date _____

Signature of School Nurse _____ Date _____