



Medication Release Form 2026-2027

This form is to be completed and signed by the Parent/Guardian. If the medication is a prescription, SRL requires the signatures from both Parent/Guardian and the child's health care provider.

Student Name _____ Today's Date _____

Date of Birth _____ Grade _____ Allergies _____

I, the parent/guardian agree to deliver the medication to the school in its original container, with the pharmacy label affixed, including the child's name, the date the medication was prescribed and the name of the medication. In the case of over-the-counter medication, **I agree to deliver the medication to the school in its original container, with the child's name and homeroom on it.**

I authorize the school to assist my child in taking his / her medication; I agree that I will not hold liable the school, or any individual of official capacity who is directed by the School Administrator to assist my child in taking said medication. (Florida Statue 232.46 Administration of medication by school personnel)

Medication _____ Method of taking _____

Medication Expiration Date _____ Dosage _____

Given at (time) _____ Parent Name _____

Parent Signature _____ Parent Phone Number _____

Physicians Statement (for Prescription medication)

The above named child _____ requires medication during the school day as follows:

Name of medication _____ Dosage _____

Time _____ Special instructions _____

This order is in effect until: _____

Date _____ Physician Signature _____

Medication Administration Documentation on separate page.