Student Name:_____Birthdate:_____Teacher:_____ Grade: _____ School Year:_____

To be completed by physician/licensed prescriber only:

		Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1							
2							

*Routes~oral (pill/capsule/chewable, liquid)~inhaled (inhaler, nebulizer)~topical skin application~topical (eye drop, ointment)~topical ear drop~injection~other (list)

List Minimal frequency between doses (especially if p.r.n.): _____

If p.r.n., list symptoms/conditions under which medication i _____

Reason for medication (optional): Medication #1 _____ Medication #2_____

Special _____

Start date if not beginning of the school year: _____ Stop date if not the end of the school year:_____

_____ _____ _____

Physician's Signature Date Physician's Printed Name

Plysicians's Phone #: Fax: Address:

To be completed by parent/guardian:

Text Box: I request and give permission for (name of child) _____to receive the above medication(s) at school according to standard school district policy and for the physician('s)/staff and school district staff to share information needed to assist my child with medication needs. (Schools require parent/guardian to bring medication in its original container).

_____ _____

Parent/guardian signature Date