Shelton School Medication Form

Today's Date _____________

Student's Name _________________________ Advisor___________ Grade___

Medication(s) _______________________ _________________________

_______________________ _________________________

- **All Prescription Medicine Must be in the labeled bottle from the pharmacy with the student's name & correct time & dosage**
- **All Over the Counter Medicine Must Be in the Original Package**

Dose of Each Tablet/Capsule/Liquid _________________mg

How Much Does the Student Take Per Dose______________(#pills/capsules)

Is This a Change? No **Yes Change in** Medication Time Dosage?

Medication to be taken: Every School Day If Forgets at Home

As Needed for: Asthma/Migraines/Other________

Critical Medicine In Case Student Must Remain at School Beyond School Hours

What Time(s) Lunch After Lunch Before School Other______________

Date to Start Medicine Today Other______________

Is there a date to stop medication No Yes Date __________

Number of Pills Sent __________

Inhaler/Epi-Pen Expiration Date______________

Count Confirmed By Nurse ____________ Signature

Parent Signature ___________________________

Contact Phone Number ______________________

E-Mail ______________________________________

All student information is kept strictly confidential.

Shelton Medication Form

Student Name: ___________________________ Grade: ________________

Date	Medicine	# In	Returned	Wasted	Reason/Notes	Counter's Initials	Witness's Initials (For Waste Only)

Print Name	Signature (with credentials)	Initials