Student Rx Information Form

Student's Name _____

DOB _____

Provider to complete the following:

Drug Name	Route	Dose	Time	Directions	Start Date	Stop Date

Restrictions and/or important side effects:

☐ None Anticipated Yes, Explain _____

Provider Signature:_____ Date: _____

Provider Name (printed) :_____ Ph: (802) _____

Parent Signature:_____ Date: _____

School Nurse Signature: _____ Date Rec'd:_____