MEDICATION CONTROL FORM

Student Name: ____

(Last) (First) (Middle)

School: ________________________________ Grade: _____ Age: ______

Prescribing Physician: ____

Physician's Address: ____

Purpose of Medication: ____

Prescription Name: ________________ Dosage: ________ Frequency: ____________

Time(s) of School Administration(s): ____

Comments regarding Prescriptions - (Side Effects, Adverse Reaction):

Student will carry and self-administer inhaler/emergency medication at school: Yes No

______________________________ ______________________

Physician's Signature Date

I hereby request that my child be administered his/her prescribed medication at school under the supervision of a designated medication dispenser. I understand that the medication will be administered as per the directions of the above-named physician. I will notify the school in writing of changes or discontinuations of this medication. I will comply with the school policy to personally deliver the medication with appropriate pharmacy labeling to the designed medication dispenser. No medications are to be in the personal possession of the student at any time. I give my permission for exchange of written/verbal information between the school/staff and the child's physician to be valid for one (1) year.

______________________________ ______________________

Parent/Guardian Signature Date

PARENT: This form must be completed and signed by Parent/Guardian and prescribing Physician. If you wish your child to receive Tylenol when needed, please Indicate: Yes No

Form is needed for a student to carry an inhaler.