

MEDICATION PASS

Student _____

Date Pass Issued _____

Expiration Date _____

Name of Medication _____
 Prescription Over-the-Counter

Amount of Medication Checked In _____

Dosage _____
 Daily Episodic/Emergency Only
 Other:

Student is authorized fo: _____
 Self-administer, supervised: Yes No
 Self-administer, unsupervised: Yes No
 Carry medication: Yes No


Signature of issuing school official _____

This pass contains confidential information. You should not share it with classmates. You must have this pass with you anytime you are carrying or receiving medication. Never leave medication unattended/accessible to other students.

MEDICATION PASS

[NAME OF SCHOOL]

STUDENT'S PICTURE



EMERGENCY CONTACT INFORMATION _____ (Parent)
 _____ (Healthcare Provider)

ISSUED TO STUDENTS AUTHORIZED TO SELF-ADMINISTER MEDICATION ONLY

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