MEDICATION FORM

ALL MEDICATION must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.

- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's well being should be sent to school.

NOTE: THE FIRST DOSE OF ANY MEDICATION MAY *NOT* BE GIVEN AT SCHOOL.

NAME OF STUDENT_____DOB_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM_____TO_____
DATE DATE

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

_____ _____
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER

ADDITIONAL MEDICATIONS

NAME OF STUDENT_____ DOB_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM_____ TO_____
DATE DATE

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

NAME OF STUDENT_____ DOB_____

NAME OF MEDICATION_____

DOSAGE_____

TIME TO BE GIVEN_____

REASON FOR MEDICATION_____

MEDICATION TO BE GIVEN FROM_____ TO_____
DATE DATE

HOW IT IS TAKEN_____
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS_____

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_____ _____
PARENT SIGNATURE/DATE PHYSICIAN SIGNATURE/DATE

_____ _____
TELEPHONE NUMBER TELEPHONE NUMBER