## Prescription Medication Form

Date _____

Student Name _____

Grade _____ Teacher _____

Diagnosis _____

Name of Medication:

Form of Medication:
□ pill □ capsule □ liquid □ inhalation
□ injection □ other (specify) _____

Dosage:

Frequency:

Common side effects:

Start Date _____ Stop Date _____

_____
**Prescriber's Signature** (required for all prescription medications)

_____
Prescriber's Name PRINTED Telephone #

_____
**Parent's Signature** Telephone #


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