MEDICATION FORM

School: _____

Date form received by the school: _____
Student: _____
Date of Birth: _____
Grade: _____
Teacher/Classroom: _____

TO BE COMPLETED BY THE PHYSICIANS OR AUTHORIZED PRESCRIBER
Name of medication:
Reason for medication (optional):
Form of medication/treatment: O Tablet/capsule O Inhaler O Injection O Nebulizer O Other:
Instructions (Schedule and dose to be given at school):
Start: O date form received Other dates:
Stop: O end of school year Other date/duration:
O For episodic/emergency events only
Restrictions and/or important side effects: O None anticipated O Yes, please describe:
Special storage requirements: O None O Refrigerate O Other:

This student is both capable and responsible for self-administering this medication: O No O Yes – Supervised O Yes – Unsupervised
This student may carry this medication: O No O Yes (special permission must be granted)
Please indicate if you have provided additional information: O On the back side of this form O As an attachment
Date: Physician Signature:
Physician's name:
Address:
Phone Number:

TO BE COMPLETED BY PARENT/GUARDIAN

I request that (name of child) _____ receive the above medication at school according to standard school policy.

I request that (name of child) _____ be allowed to self-administer the above medication at school according to the school policy.

Date: _____ Signature: _____ Relationship: _____

med form - 09/09/98