PRESCRIBED MEDICATION FORM

School____

Date form received by the school____

Student____________________________________ Date of Birth______________

Grade_______________________ Teacher________________________________

TO BE COMPLETED BY HEALTH PROVIDER OR AUTHORIZED PRESCRIBER

Reason for medication____

Name of medication____

Form of medication:

_____Tablet/Capsule _____Liquid _____Inhaler _____Injection _____Other

Instructions (Schedule and doses to be given at school) _____________________

____

Check (x)

Start _______date form received Other date___________________

Stop _______ end of school year Other date __________________

Restrictions and/or important side effects ________________________________

Storage requirements ______None ______ Refrigerate

Additional Comments ____

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Date _____________Health Provider's Signature __________________________

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) ___________________________________
to receive the above medication at school according to standard school policy.
The above medication is to be brought to school in its original container.

Date _____________ Signature _______________________________________

Relationship ____