MEDICATION FORM

NOTE: A separate form must be completed for each medication administered

Student's Name _____ Date of Birth _____ Grade __

The school nurse (or designee) has my permission to take a photograph of my student for identity purposes.

Signature of
Parent/Guardian _____ Date _____

Hospital to be called: _____ phone: _____

Doctor to be called: _____ phone _____

Name of medication _____ **Dosage:** _____

Time to be taken: _____ **Ordering Physician:** _____

Reason for medication: _____

In case of emergency call: _____ **Phone:** _____

Cell: _____ **Pager:** _____ **Work:** _____

I certify that *at least one dose* of the medication has *previously been given* and NO adverse reactions were experienced. Therefore, I give permission for the school nurse to administer the above medication to my child.

_____

Parent or Guardian Date

Note: Medication sent to school **MUST BE** in current original container from pharmacy. The medication will only be administered according to the Doctor's directions on the container.

Date	Pill Count	Brought by	Bottle Home	Initials/Initials	Comments

Revised 3/07