Long Term Medication Form

Buchanan County R-IV School District

Student Name _____ DOB_____ School_____

THE FOLLOWING IS TO BE COMPLETED BY THE PHYSICIAN

_____

Physician's Name Address Phone

Medication: _____ Dosage: _____ Form:_____

Reason for medication _____

Schedule/time to be given at school_____ Dosage to be given at school _____

If "as needed," describe indications _____

How soon can it be repeated/maximum dosage _____

Is child authorized to carry and/or administer medication? _____

Length of time recommended _____

Other pertinent information/side effects _____

_____

Date _____ Physician Signature _____

The following is to be completed by the parent/guardian

I give permission for _____ to receive the above medication at school as ordered.

I understand that it is my responsibility to provide the school with an adequate supply of the medication in the original container and to inform the school district immediately if any information on this form changes or if administration of the medication should be stopped. I further understand that the above information will be completed by the attending physician or dentist before any medication will be administered, and the medicine will be administered in accordance with their written instructions.

Date _____ Parent/Guardian Signature _____

Home phone _____ Cell phone _____ Work phone _____

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