Northeastern Schools
Medication Form

Student _____ Birth Date _____

Address _____ Phone _____

School _____ Grade _____

Section I - To Be Completed by Physician (if a prescription)

Medication and dosage or procedure required: _____

_____

Times required: _____

Possible reactions which should be reported to the physician _____

_____

Special Instructions (Including storage and sterile requirements): _____

_____

Dates when administration should begin and end: _____

_____

_____
Signature of Physician Date

_____
Physicians Name

Phone No. _____

Section II - To be Completed by Parent or Guardian

I hereby authorize the school principal or his delegate to administer the medication or procedure as instructed by the physician, and agree:

1. To deliver the medication to the person authorized to administer the medication in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
2. To notify the school if the physician is changed.
3. To submit a revised statement signed by the physician if any information originally provided by the physician is changed

Signature of Parent/Guardian _____ Date _____