MEDICATION PASS

Student _____

Date Pass Issued _____

Expiration Date _____

Name of Medication _____

☐ Prescription ☐ Over-the-Counter

Amount of Medication Checked In _____

Dosage

☐ Daily ☐ Episodic/Emergency Only

☐ Other:

Student is authorized to:

Self-administer, supervised: ☐ Yes	☐ No
Self-administer, unsupervised: ☐ Yes	☐ No
Carry medication: ☐ Yes	☐ No

Signature of issuing school official _____

This pass contains confidential information. You should not share it with classmates. You must have this pass with you anytime you are carrying or receiving medication. Never leave medication unattended/accessible to other students.

MEDICATION PASS

[NAME OF SCHOOL]

STUDENT'S PICTURE

EMERGENCY CONTACT INFORMATION

_____ **(Parent)**

_____ **(Healthcare Provider)**

ISSUED TO STUDENTS AUTHORIZED TO SELF-ADMINISTER MEDICATION ONLY

MEDICATION PASS

Student _____

Date Pass Issued _____

Expiration Date _____

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MEDICATION PASS

[NAME OF SCHOOL]

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