MEDICATION IN SCHOOL

Student: _____

Date of Birth, or age: _____

Grade: _____

Teacher/Classroom: _____

Name of medication: _____ Dosage_____

Reason for medication: _____

Form of medication/treatment: Tablet/capsule Inhaler Injection Nebulizer Other

Instructions (Schedule and dose to be given at school): _____

_____

Start: _____ Other dates: _____
Stop: _____ For episodic/emergency events only

Restrictions and/or important side effects:_____

None anticipated Self administer Yes/No

Special storage requirements: None Refrigerate Other: _____

Physician's name: _____

Address: _____

Phone Number: _____

I request that (name of child)_____receive the above medication at school according to the school policy.

I request that (name of child)_____be allowed to self-administer the above medication at school according to the school policy.

Date: _____Signature: _____Relationship: _____

School Employee who received the form:_____

Date form was received by the school: _____