EB|CS

Medication Administration Form

Student's Name: _____

Date of Birth: _____

Describe the health condition that requires medication:

_____

_____

_____

Describe the symptoms to watch for:

_____

_____

_____

Name of medication: _____

Medication Type: (Circle One)

Prescription Medication Non-prescription Medication Food/Herbal Supplement

Refrigeration required? (Circle One) Yes No

Exact dosage: _____

Time(s) to be administered: _____

Start date: _____

End date: _____

Any additional instructions:

_____

_____

_____

Must this medication accompany the child if the facility must be evacuated or if the child is transported via emergency vehicle to a medical facility? (Circle One) Yes No

I give Emmanuel Baptist Church School permission to administer the above medication.

Parent/Guardian Name: (Print) _____

Parent/Guardian Signature: _____

Date: _____