



Date _____

Pupil _____ B.D. _____ Grade ____ School _____
Last First M.I.

Attending Physician(s) _____

Physician's address _____

Physician's telephone _____ Fax _____

MEDICATION

1) Name of medications _____ Dosage _____

Time of administration _____ **Reason** for medication _____

Start _____ Stop (end of school) _____ Other _____

Comments/Possible side effects

2) Name of medications _____ Dosage _____

Time of administration _____ **Reason** for medication _____

Start _____ Stop (end of school) _____ Other _____

Comments/Possible side effects

Physician (Physician's signature **required** for **prescription** medications to be administered)

If student requires an Epi-pen, TwinJet or inhaler, plus an additional Epi-pen, TwinJet or inhaler required for bus transportation, please provide an **extra** prescription to parent so they can provide the addition pen.

Physician's signature _____ Date _____

Physician's signature for self carry/self administration of EpiPen/Inhaler _____ Date _____

To be completed by parent

I hereby request that my child be administered prescribed medication at school by school personnel. I understand that the medication will be administered exactly as per directions of my above-named physician. I will notify the school of changes or discontinuance of this medication(s) by completing a new form.

Signed _____ Date _____
Parent/Legal Guardian

Address _____