Student MEDICATION Form

Student Name ______________________ **Date of Birth/Grade** ________________ **Allergies** ______________

Primary Contact Person ______________________________________ **Phone Number** ______________

Prescription Medication

Medication	Route (oral, topical, injection, inhaler)	Dosage/Amt.	Time to Give	Reason to be Given	Duration: Ongoing/Short Term

Routine Over the Counter Medication

May be administered as needed throughout the current school year

Medication	Route (oral, topical, injection, inhaler)	Dosage/Amt.	Time to Give	Reason to be Given	Duration: Ongoing/Short Term

____________________________________ ______________________________________ ______________

Parent Signature and Date **Signature of Health Care Provider** Date

____________________________________ ____

Health Care Provider's Phone Number **Printed Name of Health Care Provider**

All medications must be received in original containers. Parents/guardians must deliver & pick up medications. Students are not to carry medication on his/her person. Any medication left over at the end of the school year will be disposed of if it is not picked up.