Prescription Medication 2016-2017

FOR STUDENTS WHO TAKE PRESCRIPTION MEDICATION AT SCHOOL:
FOR EXAMPLE, EPI-PENS, INHALERS, DAILY MEDS
*****Physician name must be on label &medication must be in the original container*****

Allergies to medication _____

Student Name & Grade _____ Date:_____

Medication name: _____

Reason for medication: _____ Prescription number: _____

Dosage _____ Route of administration: _____

Time to be given:_____ Start date: _____ End date: _____

Physician's Name **(must be on label)**:_____ Physician's Phone_____

Parent/Guardian Signature:_____PhoneNumber_____

Allergies to medication _____

Student Name & Grade _____ Date:_____

Medication name: _____

Reason for medication: _____ Prescription number: _____

Dosage _____ Route of administration: _____

Time to be given:_____ Start date: _____ End date: _____

Physician's Name **(must be on label)**:_____ Physician's Phone_____

Parent/Guardian Signature:_____PhoneNumber_____