

PHYSICIAN'S STATEMENT REGARDING PRESCRIBED MEDICINE

PLEASE SCHEDULE MEDICATION OUTSIDE OF THE SCHOOL HOURS WHENEVER POSSIBLE

Name of Pupil	Date of Birth
Name(s) of Parent(s) or Guardian(s) (M) _____ (F) _____	Telephone (M) _____ (F) _____
Address (M) _____ (F) _____	

Reason for medication:
Name of medication:
Form of medication/treatment: <input type="checkbox"/> Tablet/capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhaler <input type="checkbox"/> Other _____

INSTRUCTIONS

Schedule and dose to be given at school:

The school strongly recommends and prefers that all medication should be in a pre-measured "Unit Dose" format.

Start: Date form received at school Other start date: _____

Stop: End of school year Other stop date/duration: _____

For episodic/emergency events only

Restrictions and/or important side effects: None Anticipated

YES. Please describe:

Actions to be taken in case of reaction to medication and instructions to paramedics:

Storage and taking of medication: The general school policy is that all medication is to be stored and taken by the student in the school office unless specifically directed by the child's physician. School personnel who assist the child are not likely to have had medical training.

Special storage requirements: None Refrigerate Other:

Administration of medication: Medication may be carried by the student.
 Medication kept in the school office/classroom.

Please indicate if you have attached additional information: Yes No

Name, address, and phone of physician

Date	Signature of Physician
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