

Prescription Medication Form

Date: _____ Student Name: _____ Student Grade: _____

Student Date of Birth: _____ Student Program: _____

PHYSICIAN TO FILL OUT THIS PORTION:

Since medication for the student named above must also be administered during school hours, it is requested that school personnel administer the medication(s) listed below.

Medication Name(s) and Dosage

Instructions: _____

Special Instructions or adverse reactions that should be reported to the physician: _____

Physician's Name: _____ **Phone:** _____

Physician's Office Address: _____

Physician's Signature: _____ **Date:** _____

I understand that all medication sent to school must be in the original container labeled with the student's name, medication name, and prescribed dosage and must be brought to the school nurse upon arrival at school. I will notify the school if medication/dosage changes or if medication is to be discontinued. I understand that on occasion, non-medical personnel may administer medications.

Parent/Guardian Name: _____ **Phone:** _____

Parent/Guardian Signature: _____ **Date:** _____

This form and medication should be turned in to the school nurse upon arrival at school.

Parents or physician may fax this form to: (937-325-3990) or email to: brendalovelace@springfieldclarkctc.org