CLINTON COMMUNITY SCHOOL DISTRICT MEDICATION ADMINISTRATION FORM

Student Information:

Name:_____

Age:_____DOB:_____

☐ Elementary School ☐ Middle School ☐ High School Grade:_____

Physician:_____

Clinic/Hospital:_____

Phone:_____ Fax:_____

Non-Prescription Medication:

Medication Name:_____

Dose/Amount:_____ Time to Administer:_____

Parent/Guardian Signature:_____

Date:_____ Phone:_____

Prescription Medication: *To be completed and signed by physician and parent.

1. Name of Medication:_____
2. Dosage:_____
3. Time medication is to be administered at school:_____
4. Possible side effects:_____

   _____
5. Termination date:_____
6. Inhalers: _____ May carry on person. Student has been instructed in the proper use of this medication and is sufficiently responsible to self-administer.

   _____ May **NOT** carry on person

Physician's signature:_____ Date:_____

Parent Signature:_____ Date:_____