Medication Administration Form

☐ Elementary School Fax: 608-676-5717 ☐ Middle School Fax: 608-676-5176
☐ High School Fax: 608-676-2904

Student Information:

Name:____

Age:______________________________ 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

Name of Medication:____

Dosage:____

Time medication is to be administered at school: ____________________________

Possible Side Effects: ____

____

Termination Date: ____

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 Signature:_______________________________________ Date:_________

Parent Signature: ____ Date:_________