ALLERGIES AND MEDICATION FORM

Name of Student: ____________________________________ Date of Birth: ______________________

Address:____

ALLERGY INFORMATION

ALLERGIES: NO YES (specify): ____

Special Instructions:

____

____

____

MEDICATON INFORMATION

Condition for which drug is being administered: ____

Name of Drug: _________________________________ Dose: __________________ Route: ___________

Time of Administration: _______________________________

If PRN, frequency: _________________________

Relevant side effects: ____

Medication shall be administered from: ________________________________ to ____________________________

(Month / Day / Year) (Month / Day / Year)

Prescriber's Name/Title: ____

Telephone: ______________________________ Fax: __________________________

Address: ____

Physician's Signature ____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _______________________________Date: ____________________________

Parent's Home Phone #: ________________ Cell # _______________ Work # ______________________