PHYSICIAN'S MEDICATION INSTRUCTION FORM

Today's Date _____ Date of Prescription _____

Child's Name _____ Grade _____

Name of Medication _____

Purpose of Medication _____

Dosage and Times to be Administered _____

Termination Date of this Medication _____

Number of Tabs Sent to School _____ Need Refrigerated? Yes No

Possible Side Effects _____

Signature of Prescribing Physician _____

Physician's Phone Number _____

Parent/Guardian's Signature _____

A separate form is needed for each prescription medication your child may need to take at school. We cannot administer any kind of physician prescribed medication without permission. Thank you! 2013

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