STUDENT MEDICATION FORM

Student Name: _____ Grade: _____

A written physician's order must accompany each prescription and over the counter medication to be administered during the school day. Prescription medications must be in a properly labeled pharmacy container. Over the counter medication must be in the original container.

Please have your physician complete this form.

MEDICATION	DOSAGE	TIME AM/PM	LENGTH OF TIME	DIAGNOSIS/ CONDITION

It is my professional opinion that _____ is capable of self-administration
(student's name)

of an Asthma Inhaler and/or Epi pen and should be permitted to carry the medication.

☐ Yes ☐ No

Signature of Prescribing Physician: _____

Date: _____ Phone number: _____

Signature of Parent/Guardian: _____

Date: _____ Phone number: _____