ST EMILIE'S CATHOLIC PRIMARY SCHOOL
Growing in Grace

# ADMINISTRATION OF MEDICATION LONG TERM

Student Name:_____

Class:_____

Date of Birth: _____

Medical Condition: _____

Start Date (for administering medication): _____

Review Date: _____

Name of medication. _____

Dosage required _____

Before or after food_____

Special instructions: _____

_____

_____

Amount of medication to be stored at school: _____

Storage instructions: _____

Doctor's letter attached: Yes ☐ No ☐

In case of emergency please number from 1 – 4:

| | | **Name** | **Phone #** |
|---|---|---|---|
| • Contact Mother / Father | ☐ | _____ | _____ |
| • Contact Doctor | ☐ | _____ | _____ |
| • Ambulance | ☐ | _____ | _____ |
| • Other (*Please specify*) | ☐ | _____ | |

Parent/Guardian Name: _____
(Printed)

Date: _____ _____
(Signature)