ADMINISTRATION OF MEDICATION NON PRESCRIPTION

Student Name:____Class_______________

Date of Birth: ____

Medical Condition: ____

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)

____
(Signature)

Date: ___________