ST.EMILIE'S CATHOLIC PRIMARY SCHOOL
Growing in Grace

ADMINISTRATION OF MEDICATION

SHORT TERM

Student Name:_____Class_____

Date of Birth: _____

Medical Condition: _____

Start Date (for administering medication): _____

End Date: _____

Name of medication_____

Dosage required. _____

Before or after food _____

Amount of medication to be stored at school: _____

Storage instructions: _____

Special instructions: _____

_____

_____

_____

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: _____