

# 2019-2020 MANDATORY MEDICATION FORM

**ALL MEDICATION (prescription and OTC, including Tylenol and Advil) must be accompanied by written permission from BOTH the PARENT and PHYSICIAN.**

- **Prescription medication** must be delivered to the nurse by the parent in the original container, labeled with the student's name, medication, dosage and physician's name.
- **OTC medication** must be delivered to school by the parent in the original sealed container and labeled with the student's name.
- **Written permission** of the student's physician and parent/guardian are required, including the student's name, purpose of the medication, the time (or circumstance) at which the medication should be administered, and the length of time for which the medication is prescribed.

Only those medications which are medically necessary during school hours for a student's wellbeing should be sent to school.

**NOTE: THE FIRST DOSE OF ANY MEDICATION MAY NOT BE GIVEN AT SCHOOL.**

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NAME OF STUDENT \_\_\_\_\_ DOB \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

MEDICATION TO BE GIVEN FROM \_\_\_\_\_ TO \_\_\_\_\_  
DATE DATE

HOW IT IS TAKEN \_\_\_\_\_  
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS \_\_\_\_\_

\_\_\_\_\_  
PARENT SIGNATURE/DATE

\_\_\_\_\_  
PHYSICIAN SIGNATURE/DATE

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
TELEPHONE NUMBER

**ADDITIONAL MEDICATIONS**

NAME OF STUDENT \_\_\_\_\_ DOB \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

MEDICATION TO BE GIVEN FROM \_\_\_\_\_ TO \_\_\_\_\_  
DATE DATE

HOW IT IS TAKEN \_\_\_\_\_  
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS \_\_\_\_\_

NAME OF STUDENT \_\_\_\_\_ DOB \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME TO BE GIVEN \_\_\_\_\_

REASON FOR MEDICATION \_\_\_\_\_

MEDICATION TO BE GIVEN FROM \_\_\_\_\_ TO \_\_\_\_\_  
DATE DATE

HOW IT IS TAKEN \_\_\_\_\_  
EXAMPLE: BY MOUTH, INHALER, WITH FOOD, CRUSHED, ETC.

ADDITIONAL COMMENTS \_\_\_\_\_

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\_\_\_\_\_  
PARENT SIGNATURE/DATE

\_\_\_\_\_  
PHYSICIAN SIGNATURE/DATE

\_\_\_\_\_  
TELEPHONE NUMBER

\_\_\_\_\_  
TELEPHONE NUMBER