Medication Instruction Form

Student_____ Birth Date_____

Address_____Phone_____

School_____ Grade____ Teacher_____

Emergency Phone_____

To be completed by student's parent or physician:

Name of Medication_____

Dosage_____ How Often_____

Time to be given at school_____

Discontiuation date_____

Diagnosis requiring medication_____

Side effects, If any_____

Physician's Name Address_____

_____

Parent Signature_____ Date_____