MEDICATION ADMINISTRATION CARD
(Parent/School Information)

A) PARENT/GUARDIAN – COMPLETE AND SIGN

STUDENT'S NAME (Last, First)		BIRTH DATE (YYYY/MM/DD)	I request the school to give medication as prescribed to my child. I will notify the school promptly of any changes in medications ordered.
PARENT/GUARDIAN		DAYTIME PHONE	
PHYSICIAN	PHONE	FAX	_____ _____ (Signature of Parent/Guardian) Date (YYYY/MM/DD)

B) EACH SCHOOL STAFF MEMBER RESPONSIBLE FOR ADMINSTRATION/SUPERVISION OF MEDICATION – REVIEW AND SIGN

NAME	SIGNATURE	DATE (YYYY/MM/DD)

PLEASE HAVE YOUR CHILD'S PHYSICIAN COMPLETE THE OTHER SIDE OF THIS CARD

This information is subject to and protected by the Freedom of Information and Protection of Privacy Act. *Tumble Turn*

MEDICATION ADMINISTRATION CARD
(Medication Information to be completed by Physician)

C) PHYSICIAN – COMPLETE AND SIGN

CONDITION(S) WHICH MAKE MEDICATION NECESSARY: (**NOTE:** EpiPen is the only medication school staff will administer for anaphylactic reactions as per School Anaphylaxis Policy)

NAME OF MEDICATION	DOSAGE	DIRECTIONS FOR USE
1)		
2)		
3)		
4)		

ADDITIONAL COMMENTS, POSSIBLE REACTIONS, CONSEQUENCES OF MISSING MEDICATION, ETC.	_____ _____ (Physician's Signature) Date (YYYY//MM/DD)

PS-SCH-6 (10/05) – White (light weight cardboard)