Appendix 2

MEDICATION AND ADMINISTRATION INFORMATION

Student Name: _____ Home Telephone No.:_____

Address:_____

Date of Birth: _____ School: _____ Grade: _____

Parent/Guardian Name: _____Business Phone_____

Other Contact Name & Phone # _____

Physician's Instructions for Administering Oral Medication [to be completed by the Physician]

_____

Name of Medication: _____ Dosage [print] _____

Frequency and Method of Administration:

_____

Dates for which authorization applies (length of time medication is to be given):

_____

Possible side effects (please include or attach a drug information insert if available):

_____

Storage & Safekeeping requirements (medication is normally stored in a locked, non-refrigerated cabinet or area).

_____

Physician's Name and Address (Print) _____

_____

Physician's Phone # _____ Physician's Signature _____

NOTE: **This request will expire June 30 of each year.**