St. Mary-Basha Catholic School

Prescription Medication 2017-2018

FOR STUDENTS WHO TAKE PRESCRIPTION MEDICATION AT SCHOOL:
FOR EXAMPLE, EPI-PENS, INHALERS, DAILY MEDS
*****Physician name must be on label &medication must be in the original container*****

Allergies to medication ________________________________ ☐

Student Name & Grade ____ Date:_________________

Medication name: ____

Reason for medication: ____________________________________ Prescription number: ______________________

Dosage ____ Route of administration: _______________________

Time to be given:_______________________ Start date: ________________ End date: _______________________

Physician's Name (**must be on label**):___________________________ Physician's Phone______________________

Parent/Guardian
Signature:____PhoneNumber__________________________

Allergies to medication ________________________________ ☐

Student Name & Grade ____ Date:_________________

Medication name: ____

Reason for medication: ____________________________________ Prescription number: ______________________

Dosage ____ Route of administration: _______________________

Time to be given:_______________________ Start date: ________________ End date: _______________________

Physician's Name (**must be on label**):___________________________ Physician's Phone______________________

Parent/Guardian
Signature:____PhoneNumber__________________________