MEDICATION FORM

*****Prescription & OTC*****
Saint Catherine School

Student:_____ Age: _____
Date of Birth:_____ Grade: _____

To be completed by physician OR parent/guardian:
Reason for medication:_____
Name of medication:_____

Form of medication/treatment:
Tablet/capsule_____ Liquid_____ Inhaler_____ Injection_____
Other:_____

Instructions (Please list schedule and dose to be given at school):
TIME:_____
DOSAGE:_____

Start Medication:_____ **End Medication**:_____
Restrictions and/or important side effects:
None anticipated_____ Yes, describe:_____
Special storage requirements: None_____ Refrigerate:_____

This student is capable and responsible for self-administering this medication:
No_____ Yes, supervised_____ Yes, not supervised_____

Physician's Name:_____
Physician's Phone Number:_____
Hospital Name & Phone Number:_____

To be completed by parent/guardian:
I give permission for _____ in the _____ grade to receive the above medication at school according to standard school policy.

(Saint Catherine School requires the above medication to be brought to school in its original container.)

_____ _____ _____
Date Signature of Parent/Guardian Relationship to Student