Bible Center School

Administration of Medication

Student Name: _____ _____ _____
Last First Middle

Birth Date: _____ **Age:** _____
Month/Day/Year

Grade: _____ **Starting Date:** _____ **Ending Date:** _____

This form is to be completed at the beginning of each school year for students on long-term medication. If any change in medication or dosage takes place, a new form must be completed.

Use One Form for Each Medication

Diagnosis: _____

Name of Medication: _____

Dosage: _____

Time of Administration: _____

Method of Administration: _____

Comments:(e.g., side effects, reactions, and/or other instructions):
_____
_____

Note: The medication will be administered by designated employee(s) of Bible Center School. This may be the principal, teacher, classroom aide, secretary, nurse or other.

Physician's Name: _____
(Please Print)

Physician's Signature: _____

Date: _____ **Telephone:** _____

Parent Signature: _____
Parental Signature Approving the Administration of Medication

Date: _____, **20**____ **Telephone Number:** _____