TheSummitSchool

SY: 2023-2024

MEDICATION FORM

STUDENT CONTACT INFORMATION

STUDENT'S NAME: _____

SEX: ❑ MALE ❑ FEMALE **DOB:** _____ **AGE:** _____

Please list below all medications that your child is currently taking both at home and in school. This form must be updated each year. If your child is receiving medication during the school day, the prescribing physician must sign below. All medication must be sent to school in its original vial.

PRESCRIPTION MEDICATION (LIST ALL DAILY MEDICATION)

SCHEDULE/TIME Specify qam, qhs, bid, tid, or qid	DRUG NAME	ROUTE Specify by mouth, topically or injection	DOSAGE	ADMINISTER AT SCHOOL
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

PRESCRIBING PHYSICAN: _____ _____
PRINT PHYSICIAN'S NAME PHYSICIAN'S SIGNATURE

TELEPHONE: _____ **DATE:** _____

INSTRUCTIONS FOR EMERGENCY MEDICAL CONDITIONS
(A SEPARATE ACTION PLAN WILL BE REQUIRED FOR EACH CONDITION AT A LATER DATE)

MEDICAL CONDITION	TREATMENT
Asthma: ❑ Yes ❑ No	❑ Inhaler ❑ Nebulizer
Diabetes: ❑ Yes ❑ No	❑ Insulin
Severe Allergies: ❑ Yes ❑ No	❑ EpiPen ❑ Benadryl Food: _____ Insect: _____ Drugs: _____ Other: _____
Seizure Disorder: ❑ Yes ❑ No	

PERMISSION TO ADMINISTER PRESCRIPTION MEDICATION

I authorize The Summit School nurse to administer the prescription medications listed above to my child as directed by my child's physician.

_____ _____ _____
PRINT PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNATURE DATE