Hongwanji Mission School

STUDENT MEDICATION FORM

Date: _____

Student Name: _____ Grade/Room # _____

Name of medication: _____

Pre-measured dosage with original bottle labeled for school use: _____

Time(s) to be taken by the student: _____

Special care of medication: e.g. need to be refrigerated: _____

Possible side effects: _____

_____

Any additional information: _____

_____

Parent's Request and Authorization

I, the undersigned, request and authorize the qualified health aide to store and administer the medication noted to the student as indicated above. I understand that the qualified health personnel at Hongwanji Mission School are not trained medical personnel but is a person who is trained in standard first aid.

Parent/Guardian's Signature: _____ Date: _____

Print Parent/Guardian Name: _____

Daytime phone number: _____

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