Medication Form

All Children that are taking medication, whether administered at school or not, must fill out the medication form and update as necessary. In order for All Children Academics to ensure the safety of your child and document medicinal related changes, it is necessary that we are informed of your child's medication, dosage, and prescribing Physician.

DATE:_____

STUDENT:_____

DOB: _____

MEDICATION: _____

DOSAGE: _____

PRESCRIBING DOCTOR: _____

PHONE NUMBER: _____

EMAIL: _____

ADDRESS: _____

_____

Parent Signature Date

All Children Academics Date

See next page for dispensing medication

DISPENSING MEDICATION

As the parent or authorized representative, I_____
Parent
herby give consent to All Children Academics to dispense medication as prescribed by a duly licensed Physician (M.D.). Care must be followed by Physician directed prescription, in a labeled bottle, and removed from facility when prescription is no longer needed.

NAME OF CHILD:_____

MEDICATION TO BE DISPENSED:_____

STRENGTH OF MEDICATION:_____

DOSAGE AND TIME TO BE ADMINISTERED:_____

PERIOD OF TIME TO BE ADMINISTERED: (date)_____ to (date)_____

POSSIBLE SIDE EFFECTS:_____

REASON FOR MEDICATION:_____

PRESCRIBING PHYSICIAN:_____

PHYSICIAN PHONE NUMBER:_____

_____ _____
Signature of Parent/Guardian Date

All Children Academics Date