

## 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: \_\_\_\_\_

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Parent Signature

Date

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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