Frostig School

Administration of Medication During School Hours

ALL medications are to be in their original containers.

This section to be filled out by Prescribing Physician

Student's name:_____DOB: _____

Please list all medications this student will be taking during school hours:

Prescription Medication #1:_____Dose: _____

Times to administer medication: ☐ AM ☐ PM

Tablet: ☐ Capsule: ☐ Liquid: ☐ Other:_____

For treatment of: _____

Possible interactive side effects to watch for: _____

Prescription Medication #2:_____Dose:_____

Times to administer medication: ☐ AM ☐ PM

Tablet: ☐ Capsule: ☐ Liquid: ☐ Other:_____

For treatment of: _____

Possible interactive side effects to watch for: _____

Prescription Medication #3:_____Dose:_____

Times to administer medication: ☐ AM ☐ PM

Tablet: ☐ Capsule: ☐ Liquid: ☐ Other:_____

For treatment of: _____

Possible interactive side effects to watch for: _____

Non-prescription medication authorization

Non-Prescription Medication:_____Dose: _____

Times to administer medication: ☐ AM ☐ PM

Tablet: ☐ Capsule: ☐ Liquid: ☐ Other:_____

For treatment of: _____

Possible interactive side effects to watch for: _____

Prescribing Physician Information/Approval

Physician's Name: (Please print)_____Signature: _____

Address:_____Phone: (____) _____

This Section to be Completed by Parent/Guardian

I request that authorized Frostig staff assist my child_____in taking the above prescribed and/or non-prescribed medication at school. I also give my permission for the administering staff to speak with my child's physician concerning the above medication. I will comply with ALL Frostig medication policies and procedures.

Signature of Parent/Guardian:_____Date: _____

Cell telephone number: (____)_____Emergency telephone number: (____) _____