MILFORD PUBLIC SCHOOL

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RICK FALKENSTEIN
Superintendent

MICHELE MCCANN
Business Administrator/Board Secretary

MEDICATION FORM - for all medications **other than** asthma medications and Epi-pens

Student Name: _____ **DOB:** _____ **School Year:** _____

Allergies: _____ **Name of Medication:** _____

Dosage: _____ **Time to be given:** _____ **Termination Date:** _____

Purpose of medication: _____
Side effects to observe for: _____
Activity restrictions based on medication's effects: _____

Medication Order for Class Trip Days – please specify:

____ On the occasion of a school event or trip at which a nurse is not present, this medication may be omitted or delayed. There is no hazard to the child's health by so doing. In some cases, there may be a need to carefully monitor the child's behavior.

____ This medication should always be given at the times specified, including on class trips.

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____ Other (please explain): _____

Medication Order for Early Dismissal Days – please specify:

_____ Omit afternoon dose _____ Maintain original order

Signature of Physician: _____ **Date:** _____

Address and Phone Number of Physician/ or Stamp:

_____
_____
_____

Parents – I hereby give permission for my child to receive this medication at school as prescribed by my child's physician. I also give permission for the release and exchange of information between the school nurse and my child's physician concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need-to-know basis.

Parent Signature: _____ **Date:** _____

Where Mustangs Rule