BLOOMING TULIPS MONTESSORI SCHOOL

MEDICATION FORM

NAME OF STUDENT: _____ DOB: _____
(On pharmacy label or hand written on a non-prescription container)

TEACHER: _____ CLASS: _____

NAME OF MEDICATION: _____

DOSAGE: (amount) _____

TIME TO BE GIVEN AT SCHOOL: _____

REASON OR HEALTH PROBLEM: _____

MEDICATION TO BE GIVEN FROM: _____ TO: _____
(PERIOD- Example: days, weeks, months etc.)

HOW IT IS TAKEN: _____
(Example: by mouth, by inhaler, with food or after meals)

WHEN WAS FIRST DOSE OF THIS MEDICATION GIVEN? _____

NOTE:

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN TWO WEEKS MUST HAVE REVIEW AND APPROVAL OF A PHYSICIAN.

- Only those medications that are medically necessary during school hours for a student's attendance should be sent to school. School personnel are not responsible for any ill effects which might occur from this medication.

- The medication must be in the original container and properly labeled with student's first and last name.

_____ _____

PARENT'S/GUARDIANS SIGNATURE PHONE

_____ _____

PHYSICIAN'S NAME PHYSICIAN'S PHONE