CROSSPOINT Students

STUDENT MEDICATION FORM

Student's Name:____ Age:_____________
Parent's Name:____ Phone:_____________
Emergency Contact: ____ Phone: ______________
Prescribing Doctor: ____ Phone: ______________
Name of Medication: ____ Dosage: ____________
Possible Side Effects: ____
Instructions in case a dosage is missed: ____
Any other important information we need to know:____
____

Dates and times for administration:

Date	Time	Time Administered	(by) Initials
__________	____________am/pm	_____________am/pm	__________
__________	____________am/pm	_____________am/pm	__________
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__________	____________am/pm	_____________am/pm	__________
__________	____________am/pm	_____________am/pm	__________

Parent's Signature: ____ Date: _______________