

School Year: September _____ - June _____

This student is physically fit to attend school and is free of contagious disease and would not be able to attend school if medication was not available for administration during school hours.

Student's Name	Diagnosis
Name of Medication: _____	_____
Purpose of Medication: _____	_____
Time, Dosage and Route of Medication: _____	_____
Possible Side Effects: _____	_____
Medication Discontinue Date: _____	_____
Special Instructions or Comments: _____	_____

This medication must be administered during the school day or the pupil will not be able to attend school.

Yes _____ No _____

For Pre-Filled single dose auto injector mechanisms containing epinephrine:

This medication is to be administered for anaphylaxis:

Yes _____ No _____

This student does not have the capability for self-administration of this medication:

Yes _____ No _____

Doctor's Signature

Date

Print Name

Phone #

The Administration of Medication Policy #5330 was Approved by the Board of Education on January 18, 2006