

SAINT AGNES-SACRED HEART SCHOOL
PRIMARY SCHOOL - SELLERSVILLE, PA
MIDDLE SCHOOL & ADMINISTRATIVE OFFICE – HILLTOWN, PA

MEDICATION FORM

Student Name _____ Date of Birth _____ Grade _____

School _____ Fax # _____ Phone _____

Medication Treatment Plan to be completed by Physician

Diagnosis: _____

Medication _____ Dosage _____ Specific Time _____

Direction for Administration _____

NOTE: Medication must be supplied in the original prescription container. Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/ Special Instructions: _____

NOTE TO PHYSICIANS: Please complete the treatment plan of the back of this form for students who require any special health procedures during school hours; i.e., inhalers, nebulizer treatments, catheterization, suctioning, tube feedings, glucose testing, etc.

Printed Name or Stamp of Physician _____ Physician's Signature _____ Date _____

Physician's Phone Number _____ Physician's Fax Number _____

Parental Permission to be completed by Parent(s)/Guardian(s)

I grant the administrator or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day, including when _____ is away from school property on official school business.

Name of Student _____

Signature of Parent(s)/Guardian(s) _____ Date _____

Home Phone Number _____ Alternate Phone Number _____