MARYMOUND

Finding the good

Medication Record

To be filled out by parent or guardian

Student's name _____

Birthdate _____

Parent(s)/guardian _____

Parent/guardian work phone # _____ cell: _____

MEDICATION

Name of medication(s) _____

_____

Reason for medication(s) _____

_____

Possible side effects: _____

Dosage and method of administration _____

_____

Special instructions (e.g. on empty stomach/after meals) _____

_____

Dose and **time** to be administered during school hours _____

_____

Action to take if medication is missed _____

Prescribing physician _____ Phone _____

AUTHORIZATION

I, _____ hereby give Marymound School permission to administer the above prescribed medication. I also agree to provide the medication in its original container, including the official label of the pharmacy and the dispensing instruction of the doctor. I understand that no medication will be administered if the above conditions are not met.

Signature _____ Date _____