

ALHUDA ACADEMY
Prescription/Medication Form

For ALL Medications to be Administered During School Hours

Student's Name: _____

Grade: _____

Reason for taking medication: _____

Prescription Form must be completed by a Parent/Guardian.

Name of Medication/ Dose (mg)	Frequency (i.e. daily, twice daily, etc.)	Time of day to administer medicine	Start Date	Stop Date

Side Effects of Medication: _____

I request that an administrator or teacher assist my child in taking the above medication as prescribed by the PCP/NP during school hours.

My child is permitted to self-medicate himself/herself as prescribed by the physician or by me.

I give permission for the administrator to discuss with the prescriber and teacher as necessary information on this form.

Parent/Guardian Name

Parent/Guardian Signature

Date

Home Phone: _____ Cell Phone: _____

Office Use Only:

Administrator Signature

Date Received