MEDICATION ADMINISTRATION FORM
(for Over-the-Counter and Prescription medication)

Student's Name____

Name of Medication____
(Brand name and Generic name)

Practitioner's Name____________________________ Phone______________
(Print or type)

Allergic to any medicines? Yes_____ No_____
Please list:____

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Please type or print instructions to include proper dosage, the intervals, or time of day at which the medication/drug should be taken, the total period of time during which the medication/drug is necessary, and any other pertinent and necessary instructions.

Reason for Medication____

Time to be administered____

Special Instruction/Dosage______________________________________

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The above named student is in need of the above named medication/drug during regular school hours to maintain his/her physical health.

______________ ______________________________________
(Date) (Prescribing Practitioner's Signature)

____
(Fax Number)

Rowland Hall-St. Mark's Lower School fax number: (801) 355-0388