

Rowland Hall-St. Mark's School
Medication Administration Form 2008-2009
(For Prescription and Over-the-Counter medications, including Tylenol and Ibuprofen)

(To be completed by prescribing practitioner and returned by August 11, 2008 to become part of the cumulative health record.)

Student's Name _____

Grade _____ Teacher _____

Allergic to any medication/food, etc? Yes _____ No _____

If yes, please list: _____

Name of medication	
Dosage	
Directions/Frequency	
Reason for Medication	
Possible Side Effects	

Name of medication	
Dosage	
Directions/Frequency	
Reason for Medication	
Possible Side Effects	

Physician's Name (Please Print)

Physician Phone Number

Physician Signature

Date

Signature of Parent/Guardian

Date