COLUMBIA SCHOOLS
PHYSICIAN/PARENT MEDICATION FORM

Student Name_____ Date _____

Address _____ Teacher/Class_____

Telephone _____

Name of Medication/Prescription _____ Dosage_____

Date Administration is to BEGIN _____ END _____

Time at which medication/prescription is to be administered _____

Special instructions (including administration, sterile conditions, and storage)

_____

_____

_____

Possible Adverse Reactions _____

_____

_____

Physician's Name _____ Telephone Number _____

I understand that the medication must be received by the person authorized to administer medication in the container in which it was dispensed by the prescribing physician or a licensed pharmacist.

I also understand that I am required to notify the school in writing if the above information changed.

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician Signature Date

Adopted: November 20, 1984

Columbia Schools, Columbia Station, Ohio