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**ADMINISTRATION OF MEDICATION IN SCHOOL**

**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_

**Why Prescribed:** \_\_\_\_\_

\_\_\_\_\_

**Dosage and Frequency:** \_\_\_\_\_

**Special Directions and/or remarks:** \_\_\_\_\_

\_\_\_\_\_

**Side Effects (if any):** \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

PHYSICIAN'S STAMP: