the ANCONA SCHOOL

PHYSICIAN OR PARENT PRESCRIBED MEDICATION FORM

Student Name: ____

Address: ______________________________ City, State, Zip: ___________________________

Phone: ______________________________ Birthdate: ________________________________

Medication Name	Parent Prescribed?	Doctor Prescribed?	Medication Begin Date	Medication End Date	Dosage AM	Dosage PM

Can this medication be self-administered?

What to do if dose is missed or late (please explain)?

Possible adverse reactions and what should be done if they occur?

Other special instructions?

I relieve the Ancona School of any responsibility for the benefits or consequences of this medication and acknowledge that the school bears no responsibility for assuring that the medication is taken.

Parent Signature: Parent Printed Name:

Mobile Number: Daytime Number: Date: