MEDICATION /TREATMENT INFORMATION FORM

Student Name: _____ Grade: _____

Physician: _____

Emergency Contact(s): _____

_____

Medical condition requiring treatment during school hours: _____

_____

_____

MEDICATION / TREATMENT PRESCRIBED
(To be completed by physician: May attach copy of prescription or treatment plan)

1. Medication Information: (Name, Dose, Daily Schedule of Administration)

_____

_____

2. Treatment Information (be specific):

_____

_____

3. CONSIDERATIONS
a. Possible side effects of medication(s)/treatment and remedial action for side effects

_____

_____

b. Type of storage and safe keeping required for medication

_____

_____

1. The student named above must have this medication/treatment during school hours in order to be able to attend school. Yes ____No ____

2. The student named above is capable of administering his/her own medication without any supervision from any employee of the Carden School of Fresno staff and is capable of keeping his/her own medication in his/her possession for this purpose.
Yes ____No ____

_____ _____
Signature of attending physician Date