WEST BEND JT. SCHOOL DISTRICT NO. 1

MEDICATION CARD

To be completed by Parent and Physician (Physician's signature is NOT needed for "over-the-counter" medications: if the dosage of the "over-the-counter" medication differs from the directions on the container, a physician's signature is required.)

Student Name _____ School _____ Grade _____ Teacher _____
Address _____
Parent Name _____ Home Phone _____ Work Phone _____
Name of Medication _____ Dosage _____ Time of Administration _____
Purpose of Medication _____
Date Medication is to Begin (and end, if applicable) _____
Possible Side Effects _____
Any Special Instructions (such as refrigeration, give on empty stomach, etc.) _____

Parent Signature _____ Date _____

For Long-Term Prescription Medication:
I agree to be available for direct communication from the person(s) dispensing or administering the medication.
Physician's Name (Print) _____ Physician's Signature _____
Name of Medical Facility _____ Mailing Address _____
Phone _____ Fax _____ Date Signed _____
Specific conditions or reactions, which I should be contacted for are as follows: _____

I have instructed _____ in the proper way to use his/her Inhaler/Epi-Pen. It is my professional opinion that he/she should be allowed to carry and use their Inhaler/Epi-Pen by him/herself.

All medications are to be sent to school in the original container.
Prescription medications must be in a pharmacy bottle with a label including student name, directions, etc.

ONE MEDICATION PER CARD

4/08 PS:JML

Full Name and Initials of Person(s) Responsible for Administering Medication. _____

DATE	TIME AM/PM	INITIALS/ AMOUNT	DATE	TIME AM/PM	INITIALS/ AMOUNT	DATE	TIME AM/PM	INITIALS/ AMOUNT	DATE	TIME AM/PM	INITIALS/ AMOUNT