## WEST BEND JT. SCHOOL DISTRICT NO. 1 <br> 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
Birthdate
School
Grade
Address $\qquad$
Home Phone $\qquad$ Work Phone
Time of Administration
Parent Name


Dosage $\qquad$
Name of Medication $\square$
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)
Name of Medical Facility $\qquad$ Physician's Signature $\qquad$
Mailing Address
Date Signed
Phone $\qquad$ Fax are as follows: $\qquad$
$\qquad$

I have instructed $\qquad$ 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 must be transported to and from school by the parent/guardian and be in the original container. Prescription medications must be in a pharmacy bottle with a label including student name, directions, etc.

ONE MEDICATION PER CARD
3/1/17 PS:JML

Full Name and Initials of Person(s) Responsible for Administering Medication. $\qquad$

| DATE/TIME | $\begin{gathered} \text { \# OF } \\ \text { PILLS } \end{gathered}$ | STAFF INITIALS | DATE/TIME | $\begin{gathered} \text { \# OF } \\ \text { PILLS } \end{gathered}$ | STAFF INITIALS | DATE | DROP OFF (DO) OR PICK UP (PU) | $\begin{gathered} \text { \# OF } \\ \text { PILLS } \end{gathered}$ | SIGNATURE OF AUTHORIZED PERSON | STAFF INITIALS |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
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