MILLS RIVER SDA SCHOOL

MEDICATION & ALLERGY INFORMATION FORM

Student Name: _____ Birth Date: _____

Known Allergies: _____

The above-named student takes the following medication(s) on a regular basis:

_____PRESCRIPTION _____ OVER THE COUNTER

Medication: _____

Dosage: _____

Purpose of medication: _____

Side Effects: _____

_____

Name & phone number of doctor: _____

_____

Will it be necessary for the school to administer this medication? _____

Administering Schedule: _____

_____PRESCRIPTION _____ OVER THE COUNTER

Medication: _____

Dosage: _____

Purpose of medication: _____

Side effects: _____

Name & phone number of doctor: _____

_____

Will it be necessary for the school to administer this medication? _____

Administering Schedule: _____

Parent Signature: _____ Date: _____

Please read the Medications Policy on pages 9-10 of the Mills River SDA School Handbook.