MARDAN SCHOOL

MEDICATION FORM

My son/daughter _____

_____ Is **not** taking any medication at this time.

_____ Is taking the following medication(s):

AT SCHOOL: (**Form must be signed by prescribing physician for *any* school-administered medication**)

_____	_____	_____:_____
Name of Medication	Dosage (mg.)	Time administered AM/PM
_____	_____	_____:_____
Name of Medication	Dosage (mg.)	Time administered AM/PM
_____	_____	_____:_____
Name of Medication	Dosage (mg.)	Time administered AM/PM

AT HOME:

_____	_____	_____:_____
Name of Medication	Dosage (mg.)	Time administered AM/PM
_____	_____	_____:_____
Name of Medication	Dosage (mg.)	Time administered AM/PM
_____	_____	_____:_____
Name of Medication	Dosage (mg.)	Time administered AM/PM

NOTE: ***-Please complete this form whether your child is taking medication or not.***
-List ALL medications whether taken at home and/or at school.
-Please request a new form whenever there is any change in type or dosage of medication or if medication is being discontinued.
-Form must be signed by the prescribing physician if medication is to be dispensed by the school, including over the counter medications (such as Tylenol, Advil, etc.).

_____	_____	_____
Name of Parent/Guardian	Parent Signature	Date
_____	_____	_____
Name of Physician and Phone Number	Physician Signature	Date

FAX TO (949) 733-9234