____ __________________ ______________
Ùč å^} œ Name Date of Birth Grade

Medication:	Dosage:	Route:
Purpose of Medication:		
Time of day medication will be given at school:	Frequency: (e.g. daily)	Allergies to food, medicines, or other items? ☐NO ☐YES **List allergies:**

Anticipated number of days medication will be given at school:
☐Until the end of the current school year
☐______weeks
☐______days