BLUE SPRINGS R-IV SCHOOL DISTRICT

MEDICATION INFORMATION/SIGN-IN SHEET

Student Name: ______________________________ D.O.B.: ____________ School: ___________ Date: _______

Name of Medication: _________________________________ Prescribing Physician: _________________________

Dosage: _____________________ Time to be taken: _____________________ Color of Pill: _________________

DESCRIPTION OF MEDICATION, (COLOR, SHAPE, ETC.) ____

PURPOSE OF MEDICATION_______________________ LENGTH OF TIME FOR MEDICATION____________________

ATTENTION: ALL MEDICATION MUST BE BROUGHT TO YOUR CHILD'S SCHOOL CLINIC IN THE CURRENT PRESCRIPTION BOTTLE BY A PARENT, GUARDIAN, OR DESIGNATED ADULT.
NOTE: ANY CHANGE IN MEDICATION OR DOSAGE MUST BE MADE IN WRITING BY YOUR CHILD'S PHYSICIAN.
I herby authorize the school officials to administer the medication, as prescribed by my physician. Contact with the physician is permissible as necessary.

All over-the-counter medications require a physician's order.

PARENT/GUARDIAN SIGNATURE_________________________________PARENT /GUARDIAN INITIALS______________
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RN/HEALTH AIDE SIGNATURE__________________________________RN/HA INITIALS________________________
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DATE	QUANTITY RECEIVED	P/G INITIALS	RN/HA INITIALS	DATE	QUANTITY RECEIVED	P/G INITIALS	RN/HA INITIALS

(Revised 5/10/2010)