School Year 2021-2022

MEDICATION LIST

Dear Parents/Guardians,

Please list all medications that your child takes on a regular basis including meds that are taken during, before and after school hours. This information is necessary to update our records. Also, please list any allergies that your child has. Please return this form with your child on the first day of school.

Child's Name:
_____D.O.B_____

Medication/Dose	Time Given	Reason Taken	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			

Allergies: _____

If none, please state "none".

Parent / Guardian Signature: _____Date:_____

PHYSICIAN LIST

Child's Name:
_____D.O.B._____

Please list specialists, clinics, therapists, or other physicians consulted for your child, the problems involved, and the dates of the most recent exam.

MD or Other Specialist Phone #	Problem	Date Late Visited
1.		
2.		
3.		
4.		

May the school nurse or Social Worker contact any of the above listed health professionals in the event of a concern or a question?

Yes _____ No _____

Parent / Guardian Signature: _____Date:_____