Christ the Teacher Catholic Schools

ADMINISTRATION OF MEDICATION

Student: _____ School: _____

DOB (D/M/Y): _____ Grade: _____ Teacher: _____

Home Address: _____

Mother's Phone:	
Residence	Work

Father's Phone:	
Residence	Work

Emergency Contact: _____ Phone Number(s): _____ or _____

TO BE COMPLETED BY PHYSICIAN

Name of Student's Doctor:		**Telephone:**	
Address of Doctor:			
Name of Student's Pharmacy:		**Telephone:**	

Medication Prescribed	Dosage	Times for Administration	Side Effects

Side Effects if Medication is Not Taken:

Effective Date: _____ **Termination Date:** _____

Other Pertinent Information :

Physician's Signature: _____ **Date:** _____