File: JLCD-E-5

MEDICATION CARE FORM

Name of Student: _____ Date of Birth: ___/___/___
School:_____ Grade:_____
Name of Licensed Pre-scriber:_____
Business Telephone #:_____
Emergency Telephone #: _____

Parent/Guardian Name: _____
Home Telephone #: _____
Business Telephone #:_____
Emergency Telephone #: _____

Food/Drug Allergies: _____

Diagnoses: _____
(if not a violation of confidentiality)

Name of Medication: _____ Date Ordered: ___/___/___ Duration of Order: _____

Dosage: _____ Frequency: _____ Route of Administration: _____ Expiration Date of Medications Received ___/___/___

Specific Directions, e.g., times to be given: _____

Possible Side Effects, Adverse Reactions: _____

Quantity of Medication Received by School and Date: _____

Required Storage Conditions: _____

Delegated to (if applicable): _____ Back-up Plans (if delegate unavailable): _____

Plan for Field Trips: _____

Plans for teaching self administration, if applicable: _____

Other persons to be notified of medication administration (with parental permission): _____

Other medications being taken by the student (if not in violation of confidentiality): _____

Location where medication administration will occur: _____ Health Room: _____ Other (specify) _____

Plan for monitoring medication, if needed: _____

_____ ___/___/___ _____ ___/___/___
School Nurse Signature Date Parent/Guardian Signature Date

_____ ___/___/___
Student's Signature, if appropriate Date

Adopted January 10, 2005

Granby Public Schools - 2004

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