

Cowden-Herrick CUSD 3A

2016-2017 Medicine Registration and Administration Form

Student's name: _____ Birthdate: _____

This form must be completed before Cowden-Herrick Jr/Sr High School will administer prescription drugs or over the counter medication. Please complete the applicable medical section and the signature section at the bottom of the page.

OVER THE COUNTER MEDICATIONS: (The office will provide Ibuprofen. All other medication must be provided by the student). Please check if you authorize the school to administer two 200mg Ibuprofen tablets every 4 to 6 hours for minor aches and pains. _____

Name of medication: _____

Dosage to be given: _____

Time medication should be administered (ex: morning, noon, as needed) _____

Illness or condition being treated: _____

PRESCRIPTION DRUG:

Name of medication: _____

Dosage to be given: _____

Time medication should be administered (ex: morning, noon, as needed) _____

Illness or condition being treated: _____

Route of administration if not by mouth: _____

Date of prescription (if applicable): _____

Physician's name: _____

Parent/Guardian signature _____

Parent/Guardian phone number: _____