The Parish School
2007/2008

MEDICATION FORM-PHYSICIAN INSTRUCTIONS

To Be Completed By Parent

______________________________ ______________________________

Child's Name Name of Medication

** A separate form required for each medication*

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Child's Date of Birth

We hereby give permission for the physician listed below to exchange information about our child with The Parish School staff.

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Parent's Signature

______________________________ ______________________________

Parent's Name Printed Date

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To Be Completed by Physician and returned to The Parish School within one week of beginning treatment.

Dosage and Instructions	Reason for Medication	Desired Effects of Medication	Possible Side Effects or Contraindications

Are behavioral or performance observations necessary by the teacher? Yes: ________ No: ________

Best time for the physician to be contacted: ______________________

Prescribing Physician's Signature:______________________ Date:____________

Physician's Printed Name______________________

Address______________________Phone______________________

This form may be faxed to The Parish School at 713/467-8341,
attn: Pollyanna Campbell, Healthcare Coordinator

For medication updates, this form is available for download from the school's website at www.parishschool.org