Falk School
MEDICATION ADMINISTRATION FORM

This completed form is to accompany **any** medication to be administered at school. All medications must be sent to school in the **original container**. (See Medication Policy for additional information.)

Student Name ____ Homeroom _______

Name of medication ____

Dates to be administered ______________________ Time to be administered _________

Dosage _____________________________________ Doctor ________________________

Reason for medication ____

Special instructions ____

Keep at school ______ OR Send home each day ______

Parent signature ____ Date _____________

(For office use only)

Date												
Time												
Initials												
Date												
Time												
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Date												
Time												
Initials												
Date												
Time												
Initials												

Administered by ____________________________________ (signature) _______ (initials)

____________________________________ (signature) _______ (initials)

____________________________________ (signature) _______ (initials)