ADMINISTRATION necessary NON-PRESCRIPTION MEDICATION during the school day

COTTING SCHOOL
453 Concord Avenue, Lexington, MA 02421

Name:_________________________________**DOB:**________________ **Allergies:**_________________________

In order to assure that our students receive only medications that are safe and appropriate for them, please complete, sign and have your physician sign the following for each medication that the student would need to have administered at school. Medication must be in the original container with the original manufacturer label attached.

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Medication Name and Strength: ____

Route of Administration:___________________________ Dosage:_____________________________________

Frequency: _______________________________ Time(s) of Administration:____________________________

Indication:____

Side effects, contraindications or possible adverse reactions to be observed:________________________________

____

Medication Name and Strength: ____

Route of Administration: ___________________________ Dosage:_____________________________________

Frequency: _______________________________ Time(s) of Administration:____________________________

Indication:____

Side effects, contraindications or possible adverse reactions to be observed:________________________________

____

Medication Name and Strength: ____

Route of Administration:___________________________ Dosage:_____________________________________

Frequency: _______________________________ Time(s) of Administration:____________________________

Indication:____

Side effects, contraindications or possible adverse reactions to be observed:________________________________

____

Date: ______________________ **Parent's Signature:** ____

Date: ______________________ **Physician's Signature:** ____
(Optional)

Physician's Name: ____ Physician's Phone #:

Address: ____ ____________________________________
(Area Code)

City/Town: ____
(Zip Code)

PLEASE RETURN THIS FORM PROMPTLY and notify the school nurse of any changes whenever they occur. 2017