MADISON-GRANT UNITED SCHOOL CORPORATION
MEDICATION FORM

In order for your child to receive medication at school, you will need to complete this form and return it to the school office.

Student's Name: _____

Birthdate: _____ Grade: _____

Parent's Name: _____

Name of Medication: _____

Purpose of Medication: _____

Dosage: _____

Times when medication is to be administered: _____

Anticipated length of time student is to receive medication: _____

Physician's Name/Address/Phone Number

_____

_____

_____

I hereby authorize school personnel to administer medication as indicated above and agree to inform the school in writing of any change in medication, dosage, or times of administration for the student while at school.

_____ _____
Signature of Parent or Guardian Date