University Methodist Primary School

Special Health Needs
Medication Form

(This form must be re-submitted every six months)

Child's name: _____

Medical Condition: _____

Medication: _____

Please print detailed instructions on the following:

- Symptoms child will likely present
- How and when to administer medication
- Other emergency care actions

_____

_____

_____

_____

_____

_____

_____

Parent's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Medication	Date	Time	Dosage	Administered by (Full Name)

All medication must be in its original container and not expired.
Prescription medications must have a pharmacy label that states:

- **Child's name**
- **Prescribing physician's name**
- **Date**
- **Directions to administer medication**

University Methodist Primary School
Special Health Needs
(Continuation form)

Child's name: _____

Medical Condition: _____

Medication: _____

Medication	Date	Time	Dosage	Administered by (Full Name)