SHORT TERM MEDICATION FORM

Student_____ Date Received_____

Medication_____ # of pills or amount of liquid received_____

Times to be given_____ amount at each time_____

Teacher's Name_____ School_____

Short Term Prescription or Over the Counter Medications
(Must be in original container. Please do not send over the counter medications in a large bulk container.)

Start Date: _____ End Date: _____

Day 1 ---- Initial		Day 2 ---- Initial		Day 3 ---- Initial		Day 4 ---- Initial		Day 5 ---- Initial	
Date:		Date:		Date:		Date:		Date:	
Time:		Time:		Time:		Time:		Time:	
Time:		Time:		Time:		Time:		Time:	

Day 6 ---- Initial		Day 7 ---- Initial		Day 8 ---- Initial		Day 9 ---- Initial		Day 10 ---- Initial	
Date:		Date:		Date:		Date:		Date:	
Time:		Time:		Time:		Time:		Time:	
Time:		Time:		Time:		Time:		Time:	

Initials	Nurse's Signature

Parental Consent to give the above named medication

_____

SIGNATURE