Northern Gateway
Public Schools

Instructions for Administration of Medication

Note: All medications must be in their original containers with original labels and instructions.

Name of Student: _____

Name of Parent: _____

Address: _____ Phone (Home): _____

_____ (Work): _____

Name of Physician: _____ Clinic: _____

Address: _____ Phone: _____

Name of Medication: _____

Purpose of Medication: _____

Prescribed Dosage: _____

Frequency of Dosage: _____

Starting Date (for administration of medication): _____

Completion Date (for administration of medication): _____

Possible side effects if medication is not administered according to the prescribed schedule:

_____

_____

Precautions to be taken in storing the medication: _____

_____

Student's ability to self-administer the medication: _____

_____

Parent's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Protocol for Treatment:

_____

_____