FOR OFFICE USE ONLY – DISTRIBUTION:
☐ School Office
☐ Main Office
☐ Homeroom: ______________________

Prescription Medication at Home- CHANGE – 2025-26

It is our policy to keep in close contact with you and your physician on the monitoring of medication. The following information is necessary to comply with this policy. Written documentation is required for any change in type, dose, or timing of medication. It is the parent's/guardian's responsibility to provide the school with this documentation. Parents/Guardians should also inform the school if a dose has been missed or if medication is discontinued. Please **answer all questions** and return this completed form to the SCHOOL OFFICE.

Student Name:______________________________ Date of Birth:________________ Home Phone:________________________

Street Address:______________________________ Apt #_________ City:________________ State:_________ Zip:__________

This is a **NEW** medication ☐ This is a medication **CHANGE** ☐ This is a medication **ADDITION** ☐

TO BE COMPLETED BY STUDENT'S PARENTS/GUARDIANS

*Name of Medication:____ Dosage:____________________

Time/Frequency:____Diagnosis:__________________

Please list and special instructions, side effects, or comments staff should be aware of: _____________________________

Severe reactions that should be reported to the staff: ____

Physician's Name: _________________________________ Phone: ______________Fax:________________

*Name of Medication:____ Dosage:____________________

Time/Frequency:____Diagnosis:__________________

Please list and special instructions, side effects, or comments staff should be aware of: _____________________________

Severe reactions that should be reported to the staff: ____

Physician's Name: _________________________________ Phone: ______________Fax:________________

*Name of Medication:____ Dosage:____________________

Time/Frequency:____Diagnosis:__________________

Please list and special instructions, side effects, or comments staff should be aware of: _____________________________

Severe reactions that should be reported to the staff: ____

Physician's Name: _________________________________ Phone: ______________Fax:________________

****(Please use other side for additional medications) ****

Name of Parent/Guardian (please print): ____

Signature of Parent/Guardian: ____Date: _______________

Primary Emergency Phone: ________________________________ Secondary Emergency Phone: ______________________

REV. July 25 KRM ☐ Updated Database ____________________