COLLEGIUM CHARTER SCHOOL
SCHOOL ADMINISTRATION OF MEDICATION

SCHOOL _____

STUDENT NAME _____ DOB _____ GRADE _____ HR _____

NAME PARENT/GUARDIAN _____

DIAGNOSES	MEDICATION	DOSAGE	TIME	ROUTE

POSSIBLE SIDE EFFECTS: (PLEASE CIRCLE)

ANOREXIA SEDATION AGITATION ANXIETY CONSTIPATION NAUSEA

VOMITING HEADACHE DRY EYE FATIGUE DIZZINESS DIARRHEA

OTHER _____

SPECIAL INSTRUCTIONS _____

ADMINISTER UNTIL: _____

MEDICATION/DRUG ALLERGIES: _____

ADDITIONAL PERTINENT INFORMATION _____

I(WE) CERTIFY IT IS IMPERATIVE THAT THE MEDICATION PRESCRIBED BE ADMINISTERED DURING SCHOOL HOURS!

I(WE) GRANT PERMISSION FOR THE SCHOOL NURSE TO COMMUNICATE WITH THE HEALTH CARE PROVIDER REGARDING MEDICATION CONCERNS!

HEALTH CARE PROVIDER (PRINT) _____ PHONE _____

HEALTH CARE PROVIDER SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

M-26 REV 4/01