# St. Mark School
# Short Term
## Medication Administration Form

Parent/guardian: complete this form and bring it in to the school office with the medication in the event that your child should need medication from home administered at school. *DO NOT SEND IN YOUR CHILD'S BACKPACK.*

*All medication will be disgarded two weeks from the ending date on the form.*

**Student Name:** _____ DOB _____

☐ Prescription Name of Medicine: _____

Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

☐ Non-prescription Name of Medicine: _____

Start date for medication: _____ End date for medication: _____

Reason for administration of medication:

_____

_____

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Dosage : _____

Time for dosage at school: _____

Possible reactions or side effects of medication:

_____

_____

Any restrictions in regards to medication:

_____

_____

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As the parent/guardian of _____, I request that St. Mark Catholic School administer the above medication to my child.

Signature of parent/guardian: _____ Date: _____

Phone: _____

Emergency contact name: _____ Phone: _____