Mills River Seventh-day Adventist School
2142 Jeffress Road, Mills River NC 28759
785-2319

MEDICATION INFORMATION FORM

Student Name:_____Birth Date:_____

Known Allergies:_____

The above named student takes the following medication(s) on a regular basis:

_____PRESCRIPTION _____ OVER THE COUNTER

Medication: _____

Dosage: _____

Purpose of medication: _____

Side effects:_____

_____

Name & phone number of doctor: _____

_____

Will it be necessary for the school to administer this medication? _____

_____PRESCRIPTION _____ OVER THE COUNTER

Medication: _____

Dosage: _____

Purpose of medication: _____

Side effects: _____

Name & phone number of doctor: _____

_____

Will it be necessary for the school to administer this medication? _____

If a medication needs to be administered by the school a Daily Medication Log must be provided to the school by the parent or guardian.

Parent Signature_____**Date**_____

Please read the Medications Policy on Page 9 of the Mills River School Handbook.