

**Woodbury Public Schools
School Health Office**

Medication Form

Student _____ DOB __/__/__ Gr. __

Diagnosis _____

Name of Medication _____

Dosage/ Time _____ Give on ½ days ___ Yes ___ No

Side effects and/or comment _____

Physician Signature _____

Physician Address _____

Phone _____

NB: Medication for field trips will be withheld except for life threatening medication (inhaler or epi-pen)

Parent/ Guardian:

Please sign below to indicate your approval of your child receiving the medication stated above at school and of the school nurse administering the medication to your child. I, the parent or guardian, **MUST** bring the medication into school in the original container.

Parent/ Guardian Signature

Date