Spring Hill SCHOOL DISTRICT USD 230

Physician Prescription Medication Form

Student's Name: _____

School: _____

Prescription Medication:_____

Time and dosage at home: _____

Time and dosage at school: _____

Date medication was started: _____

Condition for which medication is given: _____

Please note that the medication is to be in the original container with the student's name.

_____
Physician Name

_____ _____
Signature of Physician Date