

Prince of Peace School

4600 Moss Creek Blvd., Hoover, AL 35226

(205) 824-7886

LONG TERM ADMINISTRATION OF MEDICATION

Child's Name: _____ Birthdate: _____

Duration of Form: _____ School Year (until medication changes)

Type of Prescription: _____

Recommended Dosage: _____

Time(s) Administered: _____

Reactions: The physician/pharmacologist is urged to list potential reactions the child might have to medication. The teacher or support personnel should note any behavioral changes.

Anticipated reactions to medication (potential impact on education)	Observed reactions to medication (actual impact on education)	Date	Observed By
Example: increased drowsiness expected for first 4-5 days of medication change	Example: Student fell asleep while talking during science class. Was asleep for 5 min.	9/18	Staff

At the school hours _____, _____ (Teacher)

will administer to _____ the medication as
(Child)

prescribed. In the absence of the teacher, _____
(Other designated person)

will administer the medication.
Signatures:

Date Signed

Parent _____

Physician _____

Person Administering Medication _____

Building Level Administrator _____