



MEDICATION ADMINISTRATION FORM

(for students who require medication during school hours)

School (please circle one): CIS / EFI

Student's Name

Family Name

First Name

Middle Name (if applicable)

Preferred Name (nickname)

Grade/Class

Date of Birth (Day/Month/Year)

Name of Medication: _____

Reason for Medication: _____

Dosage (how much medication to be given): _____

What time(s) for medication to be given: _____

Special Instructions: _____

Other Important Information: _____

Parent/Guardian Name & Signature

Date