St. Lucie County School District

STUDENT MEDICATIONS

DATE:_____

TO THE PARENT OF:_____

PLEASE LIST ALL MEDICATIONS YOUR CHILD TAKES—BOTH AT HOME AND AT SCHOOL. THIS INFORMATION WILL GIVE US A COMPLETE MEDICAL PICTURE OF YOUR CHILD'S NEEDS AND WILL ENSURE THAT YOUR CHILD WILL BE TREATED APPROPRIATELY SHOULD 911 NEED TO BE CALLED FOR ANY REASON. IT IS VERY IMPORTANT THAT ACCURATE MEDICAL INFORMATION BE AVAILABLE.

THANK YOU FOR YOUR ASSISTANCE.

1) MED._____DOSE_____TIMES GIVEN_____
2) MED._____DOSE_____TIMES GIVEN_____
3) MED._____DOSE_____TIMES GIVEN_____
4) MED._____DOSE_____TIMES GIVEN_____
5) MED._____DOSE_____TIMES GIVEN_____
6) MED._____DOSE_____TIMES GIVEN_____
7) MED._____DOSE_____TIMES GIVEN_____
8) MED._____DOSE_____TIMES GIVEN_____
9) MED._____DOSE_____TIMES GIVEN_____
10) MED._____DOSE_____TIMES GIVEN_____

THIS FORM WILL BE SENT HOME AT LEASST ONCE EACH NINE WEEK GRADING PERIOD FOR YOU TO NOTIFY THE SCHOOL OF ANY CHANGES IN YOUR CHILD'S MEDICATIONS. IN ADDITION, IF YOUR CHILD HAS ANY CHANGES IN MEDICATIONS AT ANY OTHER TIME, WE ARE REQUESTING YOU NOTIFY THE R.N. IN THE CLASSROOM THE NEXT DAY.

PARENT SIGNATURE _____ **DATE** _____