St. Lucie County School District

STUDENT MEDICATION UPDATES

DATE:_____

TO THE PARENT OF:_____

PLEASE TAKE A MOMENT TO REVIEW THE ATTACHED MEDICATION LIST FOR YOUR CHILD. IF THERE HAVE BEEN ANY CHANGES IN MEDICATIONS, DOSAGES, OR TIMES GIVEN, MAKE THE CORRECTIONS IN THE SPACES PROVIDED BELOW; THEN SIGN, DATE, AND RETURN THIS FORM TO SCHOOL TOMORROW.

THANK YOU FOR YOUR ASSISTANCE IN THIS MATTER. YOUR CHILD'S HEALTH AND SAFETY ARE OF UTMOST IMPORTANCE TO US.

NEW MEDICATION INFORMATION—PLEASE COMPLETE THE APPROPRIATE AREAS

MED._____DOSE_____TIMES GIVEN_____

___THIS IS A CHANGE TO MEDICATION NUMBER_____ON THE OTHER PAGE.

____THIS IS A NEW MEDICATION. PLEASE ADD TO LIST.

MED._____DOSE_____TIMES GIVEN_____

___THIS IS A CHANGE TO MEDICATION NUMBER_____ON THE OTHER PAGE.

___THIS IS A NEW MEDICATION. PLEASE ADD TO LIST.

MED._____DOSE_____TIMES GIVEN_____

___THIS IS A CHANGE TO MEDICATION NUMBER_____ON THE OTHER PAGE.

___THIS IS A NEW MEDICATION. PLEASE ADD TO LIST.

OR

___MEDICATION NUMBER ____ON THE OTHER PAGE HAS BEEN DISCONTINUED.

___MEDICATION NUMBER ____ON THE OTHER PAGE HAS BEEN DISCONTINUED.

___MEDICATION NUMBER ____ON THE OTHER PAGE HAS BEEN DISCONTINUED.

SIGNATURE_____DATE_____