COLLINGWOOD
SCHOOL

MEDICATION ADMINISTRATION FORM

The Medication Administration Form is to be filled out by the student's treating physician to give Collingwood School authorization to administer medications. Please return this form to the Health Center upon completion.

STUDENT INFORMATION					
Name:		Date of Birth:		Grade:	
Diagnosis:					

DISCLAIMER		
All Medications must be properly labelled in their original bottles/packaging.	Parent Initials:	
Medication's will be the responsibility of the School Nurse, delegation will include hands on training to staff or faculty by the School Nurse, as permissible by parent/guardian.	Parent Initials:	
Medication doses cannot exceed manufacturer's guidelines.	Parent Initials:	

PHYSICIAN

MEDICATIONS					
Medication	Dose	Route	Frequency/Times to be Given	Duration of Year	D/C Date
				☐	
				☐	
				☐	
				☐	
				☐	

PHYSICIAN INFORMATION		
Physician Name:	Signature:	Date:
Stamp/Contact Info:		