







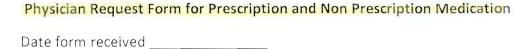








Newburg R-2 Public School *Phone 573-762-9653 ext.@ *Fax 573-762-2498





Student's Name ____



Name of Medication _____

Grade / Teacher _____ Date of Birth _____



Dose/ amount to be given ______ Time to be given ______



Route to be given _____ (Mouth, Ear, nose, Skin, other)



Will be given for what reason ______ Start date _____Stop date _____



Restrictions placed on physical education activity and for what length of time





arise.

Other notes/Adverse effects



Physician Signature: _____ Date: Phone number :



*I understand that it is the student's responsibility to come to the office at the appropriate time for the medication.



*I understand that a parent must deliver medication to the school in the original bottle with a correct label.

*I give my authorization for the physician to release information /nurse to contact the physician concerning the above medication if questions should



