Fr. John V. Doyle School
343 South Main Street
Coventry, R.I. 02816
Phone: 401-821-3756 Fax: 401-828-8513

MEDICATION CONSENT FORM **SCHOOL YEAR 20___ to 20____**

Student's Name: _____ Date of Birth: _____

Grade: _____ Room: _____ as recommended by Dr. _____

_____ _____
Parent/Guardian Signature *Date*

_____ _____
Home Phone *Work Phone*

The following is to be completed by the physician/dentist.

Diagnosis for which medication is given: _____

Name of medication: _____

Form of medication (e.g. liquid, tabs, etc.): _____

Dosage (**in milligrams, etc.**)_____

Time to be given: _____

If medicine is to be given "when needed" (prn), describe indications (ex. wheeze, pain, etc.)_____

_____

List significant side effects: _____

Length of time medication is to be taken (ex. school year etc..)_____

Other information:

_____ _____ _____
Physician's Full Name (Printed) Phone Number Date

_____
Physician's Signature

FOR OFFICE USE ONLY:
Medication received (date):
Name of medication:
Form:
Number received:
Expiration date:
For inhalers:starting count: