School Year: 2020-2021

DUBARD SCHOOL FOR LANGUAGE DISORDERS
MEDICATION INFORMATION

Student's First Name: _____ **Last Name:** _____

I. Please check one of the boxes

My child: ◯ **Takes medication daily**

◯ **Does NOT take medication daily**

II. Please fill out the following information concerning ALL medications your child takes.

A. Medication taken at HOME:

Medicine	Each Dosage (Include mg.)	Time for Each Dosage	Physician

B. Medication taken at SCHOOL:

Medicine	Each Dosage (Include mg.)	Time for Each Dosage	Physician

III. I give permission to the personnel of the DuBard School for Language Disorders to administer the medication listed below to my child:

Medicine:	
Dosage:	
Time:	
Other instructions:	
Physician:	
Beginning Date:	

IF THERE ARE CHANGES IN DOSAGE OR NEW MEDICATIONS GIVEN AT HOME OR SCHOOL, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE SCHOOL IN WRITING AND COMPLETE A NEW MEDICATION INFORMATION FORM

Date Jun 8, 2020 Parent's Name _____