

# MEDICAL ALERT AND PRESCRIBED MEDICATION RECORD

## FORM 316-1

### TO BE COMPLETED BY PARENTS/GUARDIANS OF STUDENTS WITH HEALTH CONDITIONS

The information on this form must be updated at least annually, as required by Administrative Procedure 316

Student		Birthdate
Student's Parent/Guardian (Work)	(Home)	(Cell)
Student's Parent/Guardian (Work)	(Home)	(Cell)
Emergency Contact (Work)	(Home)	(Cell)
Name of Physician		Phone

Describe the health condition which requires medication to be taken within school/work hours:

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The medication listed below is to be:

Administered by District staff

Self-administered by student

The medication listed below is located:

in a supply maintained in the school/work site administration area

on the person of the student

other:

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### THIS SECTION REQUIRES THE SIGNATURE OF YOUR PHYSICIAN

This section may be completed by attaching a current pharmacy medical label.

NAME OF MEDICATION

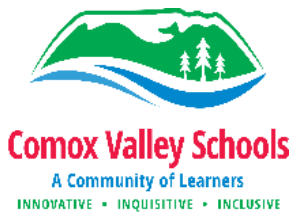
DOSAGE

DIRECTIONS FOR USE AND STORAGE

Additional comments (possible reactions, consequences of missed doses):

SIGNATURE OF PHYSICIAN

DATE



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## FORM 316-1

### TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN

I request that the school give medication as described above to my child, whose name is:

### TO BE COMPLETED BY STUDENT'S PARENT/GUARDIAN

I will notify the school promptly of any changes in the medications described on this form and will ensure that any medications provided by me to the school will be replenished as needed.

SIGNATURE

DATE

Parent/Guardian

Optional: Parent/Guardian may attach additional information

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### FOR OFFICE USE ONLY

The employees listed below are responsible for the supervision of the medication described on this form and are the only district employees trained and permitted to administer the medications listed. All qualified employees must sign below.

NAME (Please print)

SIGNATURE

DATE

SIGNATURE

DATE

Parent/Guardian