THE GROVE SCHOOL

High School Campus: (909) 798-7831 **Farm Campus: (909) 335-8668**

STUDENT MEDICATION FORM

Student Name_____ **DOB**_____

Parent/Guardian Name_____

Daytime Phone #_____ **Cell Phone#**_____

This form must be completed and submitted to the school prior to the first time **Any Medication** is required by your student during school hours for the above stated school year. NO medication, be it over-the-counter or prescription, will be administered to your student without the completion of this record and signature of parent/guardian as required below. The Student Medication Form shall be retained by the School Administrative Staff and medication will be administered per your written directions. A separate form is required for each different medication. Permission to administer medication is only valid for the school year listed above. A new Student Medication Form is required for each school year. Students are not allowed to keep on their person any medication other than an **Asthma Inhaler.**

Valid for School Year _____

Type of Medication_____

Reason for Medication_____

When to be given_____

Amount to be given_____

Known allergies_____

I authorize the Grove School staff to give my student the above listed medication according to the directions specified.

Parent Guardian Signature_____ Date_____

Date	Time	Dosage	Staff	Date	Time	Dosage	Staff