



GRADES K-8
3830 ROSEMONT AVE.
LANSING, MI 48910-4592
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MEDICATION ADMINISTRATION FORM AND DIRECTIONS

Date _____

Name of Child _____ Date of Birth _____

Address _____

Emergency Phone Number Hm _____ Work _____ Cell _____

Parents/Guardians Name(s) _____

Doctor Name _____ Phone _____

I hereby request and authorize school personnel to administer his/her prescribed medication as directed by our doctor.

Signature _____

DOCTOR ORDERS

You are hereby directed to give to _____
Name of Child

His/her medication name _____

In the amount of _____ tablets/capsules at _____ am/pm daily.

Or as follows _____

Duration _____

Possible side effects _____

Doctor's signature _____

IMMACULATE HEART OF MARY-ST. CASIMIR CATHOLIC SCHOOL CHALLENGES STUDENTS TO DISCOVER GOD'S GIFTS SPIRITUALLY, INTELLECTUALLY, SOCIALLY AND PHYSICALLY WITHIN A COMMUNITY THAT NURTURES, HONORS AND RESPECTS THE UNIQUE PERSON.