



Prescription Medicine Instructions

Student's Full Name: _____

Date medication was given to the office: _____

Name of Prescription (*Original Packaging Required*): _____

Dosing Instructions (amount, frequency, time of day): _____

Is parent contact required before dosing? _____ yes _____ no

Special Instructions: _____

Parent's Printed Name

Parent's Signature

Trinity Staff Member's Printed Name

Staff's Signature