

SACS Medication Form - ES

Student's Name _____ Age _____

Grade _____ Teacher _____

Medication _____

____ Over the Counter _____ Prescription- A Physician Form is needed for RX Medication given or kept at school >2 weeks.

Dose _____

Time to be given _____

____ Give as needed per directions on package.

Reason for medication _____

Parent's Name (print) _____

Signature _____

Date _____ Phone# _____

Parent must bring and pick-up medication. Medication must be in the original container and must not be expired.

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