Last Name First Name	Campus

Parents Emergency Contact Info: _____

Medications	Dose	Route	Schedule	Reason Prescribed

ALLERGIES: _____

REACTION: _____

Meds Your Child is Carrying on his/ her person _____

EPI PEN: _____

INHALERS: _____

Health History: _____

Permission to administer over the counter medication: YES: ☐ NO: ☐

Parent Signature: _____ Date: _____