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: ____________________