GRANGERSTUDENTS

Medical Administration Form

MED CHECK @ CHECK-IN _____ MED TEAM MEMBER SIGNATURE: _____

MED CHECK @ SPRINGHILL _____ MED TEAM MEMBER SIGNATURE: _____

ADDITIONAL MEDICAL CHECKS

MED TEAM MEMBER SIGNATURE _____ Date: _____

MED TEAM MEMBER SIGNATURE _____ Date: _____

CONSENT FOR AS NEEDED MEDICATION:

I hereby authorize medical staff to administer as needed medication to my student while in attendance at this event.

Parent/Guardian Signature: _____

Date: _____

Student's Name:	Parent/Guardian Name:						
Student's Date of Birth:	Parent/Guardian Number:						
Allergies:							
One medication per line, include dose:	**The boxes below are for Nurse's use only:**						
Breakfast meds:	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
DO NOT WRITE							
Lunch Meds:							
NURSES							
Dinner meds:							
USE							
Bedtime Meds:							
ONLY							
PRN (as needed)							