afterschool VILLAGE

1. Print out this form & have your child's Dr. complete & sign it.

MEDICATION INFORMATION

MUST BE FILLED OUT AND SIGNED BY A PHYSICIAN

PHYSICIAN CONSENT

As a patient under my care, I hereby approve and prescribe the administration of the following medication during school hours.

		1 Tab/2 Tab (Regular or Extra Strength)
May Acetaminophen/Ibuprophen be given for Headache?	O No O Yes	_____
May Acetaminophen/Ibuprophen be given for fever?	O No O Yes	_____
May Acetaminophen/Ibuprophen be given for pain?	O No O Yes	_____
May Benadryl or Claritin be given for allergies? (Benadryl may cause drowsiness and/or dizziness)	O No O Yes	_____
May Tums / antacid be given?	O No O Yes	_____

Rx Medication: _____ Purpose: _____ Dosage: _____

Parents please note: Prescription medications listed here should also be entered on the Magnus Vital Health Record

Rx Medication: _____ Purpose: _____ Dosage: _____

Special Instructions: _____

ASTHMA O No O Yes

If yes, please complete the following:

Date: _____

Medication: _____ Dosage: _____ Time: _____

Date: _____ *(to be filled out by school official if/when new medication is received during school year)*

Medication: _____ Dosage: _____ Time: _____

PHYSICIAN INFORMATION

If you have more medication please list on a separate piece of paper

_____ _____

Physician's Name Phone Number

_____ _____

Address City/State/Zip

_____ _____

Physician's/Provider's Signature **Date**

Physician's/Provider's Stamp and/or License #:

Covid-19 - If you answer "Yes" to any of the following, please explain with as much detail as possible.

Has there been a confirmed positive test result for Covid-19? ☐ Yes ☐ No

Has there been know exposure to Covid-19? ☐ Yes ☐ No

Has there been a likley exposure to Covid-19? ☐ Yes ☐ No

Currently experiencing cold, fever/flu like symptoms, or have experienced these symptoms in recent weeks? ☐ Yes ☐ No