Colquitt County School Health

SHORT TERM MEDICATION FORM

Short Term Prescription or Over the Counter Medications
(Must be in original container. Please do not send over the counter medications in a large container such as Tylenol.)

Student Name:_____ **School:_____**

1. Medication _____
   Amount to be given: _____
   Start Date: _____ End Date _____

	Day 1	Day 2	Day 3	Day 4
Date				
Time				
Initials				
	Day 5	**Day 6**	**Day 7**	**Day 8**
Date				
Time				
Initials				

2. Medication _____
   Amount to be given: _____
   Start Date : _____ End Date _____

	Day 1	Day 2	Day 3	Day 4
Date				
Time				
Initials				
	Day 5	**Day 6**	**Day 7**	**Day 8**
Date				
Time				
Initials				

3. Medication _____
   Amount to be given: _____
   Start Date : _____ End Date _____

	Day 1	Day 2	Day 3	Day 4
Date				
Time				
Initials				
	Day 5	**Day 6**	**Day 7**	**Day 8**
Date				
Time				
Initials				

4. Medication _____
   Amount to be given: _____
   Start Date : _____ End Date _____

	Day 1	Day 2	Day 3	Day 4
Date				
Time				
Initials				
	Day 5	**Day 6**	**Day 7**	**Day 8**
Date				
Time				
Initials				

Initials	Nurse's Signature

Parental Consent to give the above named medication.

Signature **Date**

Revised 07/07