Frostig*School*
Health/Medication Information Sheet

Child's Name: ________________________________ DOB: ____/____/_____ Home Phone: (____) ____-_______

Does your child have any special medical concerns (i.e. **allergies**, surgeries, migraines, seizures, ADD, ADHD, OCD, etc.) that Frostig staff should know in order to better serve your child? YES: _____ / NO: _____

Please list any allergies: ____ / NKA (no known allergies): _____

If yes, please give a brief explanation and list any allergies, allergic reactions and or symptoms that staff should be on alert for: ____.

Parents please list **ALL** medications your child is currently taking either at home or while at school. Also, please notify Kathleen Birk, DMS (Kathleen@frostig.org) whenever there is a change in your child's medication or dosage.

MEDICATIONS

Please list ALL medications taken by your child either at home or while at school. Remember to update this list whenever a change in medication occurs. This will help staff better service your child.

Medication	Dosage	Time/s taken both at home and or school
1.		
2.		
3.		
4.		
5.		

- If your child needs medication during school hours please be sure to have your child's physician fill out a "Request for Medication" Form.
- We strongly urge you to provide us with a (3) day supply of your child's medications in case of emergency/earthquake.
- Please remember to update the front office when you have a change in home/work phone numbers. Please remember to update the designated medication staff (DMS) whenever a change in your child's medication/s occurs.

Parent/Guardian Signature: ________________________________ Date: _____/_____/_____

Date received: __________ Initials: __________