2024-2025 PRESCRIBED AND OVER-THE-COUNTER MEDICATION PROFILE

Parent Name: _____ Student Name: _____

MEDICATION INFORMATION

Please complete this form if your child will require prescription, over-the-counter, or emergency medications/treatments at any time while at Mainspring Academy. All sections must be complete and a physician's signature must be included.

MEDICATION 1

Name of medication _____

Purpose of medication_____

Medication dose_____

Medication Type (Choose One): ☐ **Prescription** ☐ **Over-the-counter** ☐ **Rescue**

Medication Frequency (Choose One): ☐ **Daily** ☐ **Emergency** ☐ **As needed (please specify parameters below)**

If daily, preferred time to administer (Choose One) ☐ **9:30am** ☐ **10:30am** ☐ **11:30am** ☐ **12:30pm** ☐ **1:30pm** ☐ **Before Meal**

Does the medicine need to be taken with food or water? _____

How long will your child need to take this medication?_____

If this is a PRN (as needed) medication, what is the criteria for administration?

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE_____**Date**_____

MEDICATION 2

Name of medication _____

Purpose of medication_____

Medication dose_____

Medication Type (Choose One): ☐ **Prescription** ☐ **Over-the-counter** ☐ **Rescue**

Medication Frequency (Choose One): ☐ **Daily** ☐ **Emergency** ☐ **As needed (please specify parameters below)**

If daily, preferred time to administer (Choose One) ☐ **9:30am** ☐ **10:30am** ☐ **11:30am** ☐ **12:30pm** ☐ **1:30pm** ☐ **Before Meal**

Does the medicine need to be taken with food or water? _____

How long will your child need to take this medication?_____

If this is a PRN (as needed) medication, what is the criteria for administration?

_____

_____

_____

_____

PHYSICIAN'S SIGNATURE_____**Date**_____