

# Change in medication form 2011-2012

**Please complete the following:**

Student's name: \_\_\_\_\_ Date: \_\_\_\_\_

**In order to best understand your child's needs, we ask that you complete this form:**

- When any changes in medication occur (increase or decrease in dosage, time of day, discontinuation, or new medication all together).

| Medication/dosage | Reason for medication | Time to be administered: | Possible side effects: |
|-------------------|-----------------------|--------------------------|------------------------|
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Reason for the change \_\_\_\_\_  
 Physician monitoring medications \_\_\_\_\_  
 Physician contact: Address \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Please note** if for some reason your child's dose has been missed in the morning, we will call you to bring the medication to school or to pick up your child.

Revised: 8/1/10