

MARDAN CENTER OF EDUCATIONAL THERAPY

MEDICATION FORM/TREATMENT PLAN

My son/daughter _____

_____ Is not taking any medication at this time.

_____ Is taking the following medication(s):

AT SCHOOL: (Form must be signed by prescribing physician)

Name of Medication Dosage (mg.) _____:
Time administered AM/PM

Name of Medication Dosage (mg.) _____:
Time administered AM/PM

Name of Medication Dosage (mg.) _____:
Time administered AM/PM

AT HOME:

Name of Medication Dosage (mg.) _____:
Time administered AM/PM

Name of Medication Dosage (mg.) _____:
Time administered AM/PM

Name of Medication Dosage (mg.) _____:
Time administered AM/PM

- NOTE:**
- Please complete this form whether your child is taking medication or not.
 - List ALL medications whether taken at home and/or at school.
 - Please request a new form whenever there is any change in type or dosage of medication or if medication is being discontinued.
 - Form must be signed by the prescribing physician if medication is to be dispensed at school, including over-the-counter medications (such as Tylenol, Advil, etc.)

Name of Parent/Guardian Parent Signature _____
Date

Name of Physician and Phone Number Physician Signature _____
Date

Phone: (949) 733-1500
Fax: (949) 733-9234