Student Medication Administration Form
Wythe County Public Schools

Student Full Name Last, First, Middle

Date mm/dd/yyyy

Student School Name

Select School Name Here

Grade

Select Grade Here

Teacher Name

Special medical conditions (allergies, asthma, bee stings, diabetes, heart problems, medication allergies)

Medications taken by your daughter/son may cause allergic reactions, changes in personality, side effects, and/or other issues. Please list any medications student is consuming at home or at school. ***Please do include inhalers.***

Medication(s)	Dosage	Time(s) Taken	Taken at Home	Taken at School

Primary Physician Name and Telephone Number

List any medical specialists or clinics for daughter/son.

I would like the school nurse to contact me regarding obtaining medical insurance for daughter/son.

☐ No ☐ Yes

Is student covered by any of the following?

☐ FAMIS ☐ FAMIS Plus (Medicaid) ☐ None ☐ Private Insurance

My daughter/son has trouble swallowing pills.

☐ No ☐ Yes

Parent/Legal Guardian Printed Name

Parent/Legal Guardian Signature

Revised 03/2016