

**THE WOLF SCHOOL
MEDICATION FORM
2016/2017**

Student's Name: _____

Date: _____

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

1. Upon admission
2. At the beginning of each school year

Complete the Change of Medication Form when any changes in medication occur (increase or decrease in dosage, time of day, discontinuation, or new medication all together).

At the present time, the Wolf School does not have a full time nurse.

*** If your child is currently on a controlled substance, which must be administered during school hours, please contact our Head of School to discuss a plan.**

Please complete the following:

Medication/Dosage

Reason for Medication

Time to be Administered

Possible Side Effects _____

Physician Monitoring Medications _____

Physician Contact: Address _____ Phone _____

Medication/Dosage

Reason for Medication

Time to be Administered

Possible Side Effects _____

Physician Monitoring Medications _____

Physician Contact: Address _____ Phone _____