The Leadership School at Kieve

Medical Concern Form

Student Name

I give the Leadership School Staff my permission to administer (please circle)

Parent/Guardian

Allergies

Tylenol Advil

to my son / daughter

Phone Number of above

Please list any emotional/medical concerns your son/daughter may have.

Please list all medications that you are sending with your child

Med name

Dose/Frequency

Circle Route: Injection / oral / topical / other

Time of Admin	M	T	W	Th	F	S	S
AM							
PM							
Noon							
As Needed							
Other							

Med name

Dose/Frequency

Circle Route: Injection / oral / topical / other

Time of Admin	M	T	W	Th	F	S	S
AM							
PM							
Noon							
As Needed							
Other							

Med name

Dose/Frequency

Circle Route: Injection / oral / topical / other

Time of Admin	M	T	W	Th	F	S	S
AM							
PM							
Noon							
As Needed							
Other							

I certify as parent/guardian of above-named child that the medications listed above are accurate in name/dosage/route of administration and frequency, to the best of my knowledge. Through completion of this form, I give the staff of The Leadership School permission to administer the above medications(s)/treatments to my child in my absence. **I understand that:** my child will not be allowed to keep any medication in his/her cabin. Prescribed medications must be accompanied by a pharmacy label containing: the Rx number, the medication name, dosage, administration directions, and the child's name. Whenever possible, a copy of the doctor's prescription or letter should be sent to clarify any discrepancies. All non-prescription medications/vitamins/etc. must be in their original containers, clearly labeled with the child's name, name of the medication and directions for use. I may be reached at the contact number indicated above if you have any questions or concerns.

Parent/Guardian Signature: **Date:**

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	Time of Admin	M	T	W	Th	F	S	S
Med name	AM							
	PM							
	Noon							
Dose/Frequency	As Needed							
Route:Injection/oral/topical/other	Other							

	Time of Admin	M	T	W	Th	F	S	S
Med name	AM							
	PM							
	Noon							
Dose/Frequency	As Needed							
Route:Injection/oral/topical/other	Other							

	Time of Admin	M	T	W	Th	F	S	S
Med name	AM							
	PM							
	Noon							
Dose/Frequency	As Needed							
Route:Injection/oral/topical/other	Other							

	Time of Admin	M	T	W	Th	F	S	S
Med name	AM							
	PM							
	Noon							
Dose/Frequency	As Needed							
Route:Injection/oral/topical/other	Other							

	Time of Admin	M	T	W	Th	F	S	S
Med name	AM							
	PM							
	Noon							
Dose/Frequency	As Needed							
Route:Injection/oral/topical/other	Other							

This sheet has been reviewed by: ____________________

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