



Medication Information Form

New Orleans Adventist Academy

Student's Name _____
Last First Middle

Birthdate _____ Medication Allergies Yes No If yes, please explain _____

It is necessary for the School Nurse or Designated School Personnel to know the medication your child is on in case of any medical situation. This form is confidential and used only for the protection of your child.

Is there any history of mental, emotionally, or counseling services your child has undergone? Yes No If yes, please explain _____

Current Medications

My child is not on any medications at this time. I will inform the School Nurse / Designated Official if any medication is prescribed.

My child is currently taking the following medications:

Medication Name	Dose	Medication Purpose	Frequency
1.			
2.			
3.			
4.			

Parent / Guardian Signature _____

Printed Name Parent / Guardian _____

Date (Month / Day / Year) _____