Prescription Medicine Form

Note: This section must be filled out whenever a new medication is prescribed. All students must report all prescriptions to be stored and administered through self-administration except asthma inhalers.

Student Name _____ Grade _____

To Be Completed by Physician (if medicine is prescribed below):

I request that my patient (named and identified above) receive the following medication while in residence at the Mississippi School of the Arts.

Diagnosis: _____

Name of Medication: _____

Prescribed dosage and means of administration:

_____

_____

Time(s) to be administered: _____

Expected duration of treatment: _____

Possible side effects/adverse

reactions:_____

Physician's Name _____

Signature _____

Phone Number _____ **Date** _____