Medication Form Completion Request for medications that need to be given at school or daycare

We must have information about the medication and dose to process.

Patient Name: _____ Patient Date of Birth: _____

Parent/guardian section filled out on Physical or Medication form: ▢ Yes (if no, Please complete)
Would you like to (check one):

▢ Receive form through the Patient Portal. Forms will be returned via the Patient Portal within 7 business days (M-F). Please select one of the following:

- ▢ I have a Portal account
- ▢ I need to set up a Portal account

▢ Pick up form from clinic. Forms will be completed within 5 business days, M-F. Please provide the best phone number to call when ready for Pick-up): _____

Comments**?** _____

Medication Name: _____ Check one: ▢ Pill ▢ Capsule ▢ Liquid ▢ Chewable ▢ Other

Current weight (if known): _____Reason for medication: _____

Strength of medication (e.g., "mg each" or "mg per ml"): _____

Dose_____ Time of Dose_____

The Patient is in: ▢ Elementary School ▢ Middle School ▢ High School

If Patient is in Middle or High School, are they able to self-carry and self-administer this medication? ▢ Yes ▢ No

Medication refill needed? ▢ Yes ▢ No

Medication Name: _____ Check one: ▢ Pill ▢ Capsule ▢ Liquid ▢ Chewable ▢ Other

Current weight (if known): _____Reason for medication: _____

Strength of medication (e.g., "mg each" or "mg per ml"): _____

Dose_____ Time of Dose_____

The Patient is in: ▢ Elementary School ▢ Middle School ▢ High School

If Patient is in Middle or High School, are they able to self-carry and self-administer this medication? ▢ Yes ▢ No

Medication refill needed? ▢ Yes ▢ No

For additional medications, use the next page.

OFFICE USE ONLY: *Today's date:* _____ *Date of last WCC:* _____

Preferred Provider (or last WCC Provider): _____*Assigned to:* ▢ *PCP* ▢ *OCD*

Additional Medications:

Medication Name: ____________________________ Check one: ▢ Pill ▢ Capsule ▢ Liquid ▢ Chewable ▢ Other

Current weight (if known): _____________________Reason for medication: _____________________

Strength of medication (e.g., "mg each" or "mg per ml"): ______________________

Dose_________________________ Time of Dose______________________

The Patient is in: ▢ Elementary School ▢ Middle School ▢ High School

If Patient is in Middle or High School, are they able to self-carry and self-administer this medication? ▢ Yes ▢ No

Medication refill needed? ▢ Yes ▢ No

Medication Name: ____________________________ Check one: ▢ Pill ▢ Capsule ▢ Liquid ▢ Chewable ▢ Other

Current weight (if known): _____________________Reason for medication: _____________________

Strength of medication (e.g., "mg each" or "mg per ml"): ______________________

Dose_________________________ Time of Dose______________________

The Patient is in: ▢ Elementary School ▢ Middle School ▢ High School

If Patient is in Middle or High School, are they able to self-carry and self-administer this medication? ▢ Yes ▢ No

Medication refill needed? ▢ Yes ▢ No

Medication Name: ____________________________ Check one: ▢ Pill ▢ Capsule ▢ Liquid ▢ Chewable ▢ Other

Current weight (if known): _____________________Reason for medication: _____________________

Strength of medication (e.g., "mg each" or "mg per ml"): ______________________

Dose_________________________ Time of Dose______________________

The Patient is in: ▢ Elementary School ▢ Middle School ▢ High School

If Patient is in Middle or High School, are they able to self-carry and self-administer this medication? ▢ Yes ▢ No

Medication refill needed? ▢ Yes ▢ No

Medication Name: ____________________________ Check one: ▢ Pill ▢ Capsule ▢ Liquid ▢ Chewable ▢ Other

Current weight (if known): _____________________Reason for medication: _____________________

Strength of medication (e.g., "mg each" or "mg per ml"): ______________________

Dose_________________________ Time of Dose______________________

The Patient is in: ▢ Elementary School ▢ Middle School ▢ High School

If Patient is in Middle or High School, are they able to self-carry and self-administer this medication? ▢ Yes ▢ No

Medication refill needed? ▢ Yes ▢ No

Medication Name: ____________________________ Check one: ▢ Pill ▢ Capsule ▢ Liquid ▢ Chewable ▢ Other

Current weight (if known): _____________________Reason for medication: _____________________

Strength of medication (e.g., "mg each" or "mg per ml"): ______________________

Dose_________________________ Time of Dose______________________

The Patient is in: ▢ Elementary School ▢ Middle School ▢ High School

If Patient is in Middle or High School, are they able to self-carry and self-administer this medication? ▢ Yes ▢ No

Medication refill needed? ▢ Yes ▢ No