West Plains R-7 School Medication Form
Before and After School Program

Students Name:_____

Date Of Birth:_____ Gender M F Grade_____

Parent Guardian_____

Home Phone _____ Work Phone_____

Emergency Contact_____

Home Phone_____ Work Phone_____

Additional Phone Numbers_____ Family Doctor_____

Drug/Food Allergies (Be Specific)_____

Significant Health Programs_____

Medications Taken at Home_____

The West Plains R-7 School District has my permission to administer the following Over-the-Counter medications checked:

_____ Sting kill swabs for insect bites/bee stings

_____ Calamine Lotion or irritated/itching skin (not to exceed twice daily)

_____ Clean Abrasions/Wounds with soap and water/Hydrogen Peroxide-Apply Antibiotic Ointment

Parent/Guardian Signature_____ Date_____

West Plains R-7 District has my permission to administer the following medication:

Medication_____ Amount to give_____

Doctor Prescribing_____ Time to give _____

Reason taking medication_____

Parent/Guardian Signature_____ Date_____

******NOTE TO PARENTS THERE WILL BE NO NURSE AVAILABLE DURING BASE HOURS*****