Hartford Union High School District

805 Cedar Street
Hartford, WI 53027
www.huhs.org
Phone 262.670.3200
Fax 262.673.8943

MEDICATION CARD

One card per medication

To Be Completed By Parent

Date:

Student's name: Grade School Year:

Name of drug: Dosage:

Purpose of medication:

Date medication is to begin: Date medication is to end:

Time of administration: Possible side effects:

Parent's signature: _____ Date: _____

To Be Completed by Physician for Prescription Drugs

I agree to available for direct communication from the person dispensing or administering the medication. Specific conditions under which I should be contacted regarding the condition or reactions of the student are:

Physician's Signature: _____ Date: _____

Address: _____

Phone Number: _____