

**High Point Baptist Academy  
Prescription Drug Administration**

Student name: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Frequency/ Time of day: \_\_\_\_\_

Dates: \_\_\_\_\_  Daily for entire school year

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_