ST. JOHN'S NORTHWESTERN ACADEMIES

NAME (LAST, FIRST, MI.) : _____

DATE OF BIRTH (MM/DD/YYYY) : _____

BIRK Infirmary Medication Form

The following medication form is to be completed and signed by the prescribing health care provider. Any changes or discontinuation in medication regimen during the school year must be written by the health care provider. Changes in prescriptions may be forwarded directly to the Infirmary by fax, email or upload to our health portal. Because of the structure and activity schedules found at SJNA, medication distribution times are integrated into the daily routines. If you have questions, please contact the Infirmary.

MEDICATION	DOSE	FREQUENCY / TIME	DIAGNOSIS

Please use the back side of this form to list additional medications.

SPECIAL INSTRUCTIONS - Please provide special instructions below (ie; can refuse on weekends, may not refuse, morning medications can be taken later on the weekend, etc.)
_____
_____
_____
_____

PHYSICIAN INFORMATION / PARENT AUTHORIZATION
Prescribing Provider's Signature: _____ Date: _____
Print Prescribing Provider's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Signature of Parent or Guardian: _____ Date: _____

ST. JOHN'S NORTHWESTERN ACADEMIES

NAME (LAST, FIRST, MI.) : _____

DATE OF BIRTH (MM/DD/YYYY) : _____

MEDICATION	DOSE	FREQUENCY	DIAGNOSIS