ST. JOHN'S NORTHWESTERN ACADEMIES

NAME (LAST, FIRST, MI.) : _____

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

Medication Change Form

The following medication change form MUST 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. If you have questions, please contact the Infirmary.

ALL OTHER MEDICATIONS WILL BE ADMINISTERED FOLLOWING PRESCRIPTION ORDERS, UNLESS NOTED ON A MEDICATION CHANGE FORM.

PLEASE START THE MEDICATION(S) LISTED BELOW

MEDICATION	DOSE	FREQUENCY / TIME	DIAGNOSIS

PLEASE DISCONTINUE THE MEDICATION(S) LISTED BELOW

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: _____