YORKTOWN HIGH SCHOOL CHORAL MUSIC PROGRAM

2009-2010 Self-Medication Form

Student's Name:		
First Nar	ne Last Name	
Please list all prescription medications, the dosage and frequency. Write " NONE " if no medication <u>is being taken</u> :		
Medication	Quantity (in mg's)	Rate (dosage per day)
Please list all OVER-THE-COUNTER medications the student will be allowed to use. Write " NONE " if no medication will be taken:		
Please list all allergies:		
By listing this information, you are giving the student permission to self-medicate pursuant to the instructions and dosage information you have provided. Medications not listed will be considered contraband and will be confiscated.		
It is the responsibility of the parent to update the medical information throughout the year. All information provided in this document will be kept in the strictest confidence. Information will only be shared with those that require it in order to contribute to the health and well being of the student.		
Student signature		Date
Parent signature		Date

If your child is not taking medication, or will not need to take "over-the-counter" medication, please sign this document to acknowledge that you read and understand.