University United Methodist Day School

Special Health Needs Form

(This form must be re-submitted every six months)

Child's name: ____

Medical Condition: ____

Medication: ____

Please print detailed instructions on the following:

- Symptoms child will likely present
- How and when to administer medication
- Other emergency care actions

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Parent's Signature: ____________________________ Date: __________

Physician's Signature: ____________________________ Date: __________

Medication	Date	Time	Dosage	Administered by (Full Name)

All medication, including over the counter medication, must be in its original container with a pharmacy label that states:

- **Child's name**
- **Prescribing physician's name**
- **Date**
- **Directions to administer medication**

University United Methodist Day School
Special Health Needs
(Continuation form)

Child's name: ____

Medical Condition: ____

Medication: ____

Medication	Date	Time	Dosage	Administered by (Full Name)