

**SJNMA Infirmary Health Record**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Month / Day / Year

**MEDICATION FORM**

TO BE COMPLETED BY HEALTH CARE PROVIDER (ie. MD, DO, NP, PA)

In accordance with the St. John's Northwestern Military Academy Medication Policy, all medications, including prescriptions, over-the-counters, supplements and vitamins, must be prescribed by an authorized health care provider with a written order and directions for use. 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 faxed directly to the Infirmary at 262-646-7212 or emailed to: infirmary@sjnma.org.

Because of the structure and activity schedules found at SJNMA, medication distribution times are integrated into the daily routines. If you have questions regarding the medication times, please contact the Infirmary nurse at 262-646-7125.

<i>MEDICATION</i>	<i>DOSE</i>	<i>FREQUENCY</i>	<i>DIAGNOSIS</i>

\*Please provide any special instructions, for example: student may refuse medication on non-school days, weekends, evenings, or student may not refuse. If student has permission to carry medications (i.e.: rescue inhaler, Epipen, insulin), document directions under special instructions. If a new medication is replacing another, please provide the \*\*discontinuation order.

<p><b>*Special Instructions</b> _____ _____</p> <p><b>**Discontinuation Order:</b> _____ _____</p>
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**Prescribing Health Care Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Prescribing Health Care Provider's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_