Attachment HA 2: Current Medications for Re-enrollment to HA

Current Medications

Student name: _____ DOB: _____

Name of Primary Care Physician:

_____Phone:_____ _____

Name of Prescribing Health Care Practitioner:

_____Phone: _____

List of daily medication and dosages (***please include those given at home***):

Name of Medications	Dosage	Time or times given

Please notify the school nurse of any medication changes, including dosage changes during the school year. This will allow for assessment and feedback to parents/guardians regarding school performance.

_____Date: _____
Parent/guardian signature