

MEDICATION ADMINISTRATION SCHOOL FORM

Student name					
	Last	First	Gend	er DOB	
Name of Medication	Cortef/ Hydroco	rtisone (mg/	(tab) Date of page	rescription	
Dose prescribed		Do		et, liquid, injection, etc.)	
Route	Time sc	heduled	·		
Diagnosis or purpose	of medication	Adrenal In	<u>sufficiency</u>		
Needs total/ par	tial assistance with	n medication	Self- suffici	ent with medication	
Special Instructions a	and/ or comments:				
The student for whor	n this medication i	is prescribed is	under my care.		
Print name/ Title 4650 Sunset Blvd.	Los Angeles,	Signature CA	90027	Date (323) 361- 2129	
Address	City	State	Zip Code	Telephone	
I authorize Children's Hosp				polism to release my child, iagnosis and Treatment to	
			School.		
Date	Signature of Parent/ Guardian		Pr	Print Name	
() Home telephone	()Ce	Cell telephone Work telephone			