Authorization for Medications to be taken During School Hours

The following section is to be completed by the Parent/Guardian:

Child's Name: ______________________________ ______ __________

Last, First Sex Date of Birth

______________________________ (____) __________

Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized person or permitted to medicate self as also authorized by me and my physician (see below).

__________ / ______________________ (____) ________________

Date Parent/Guardian Signature Home Number

The following is to be completed by the PHYSICIAN:
Diagnosis for which medication is given:______________________________

Name of Medicine______________________________ Form__________

Dose______________If medicine is to be given DAILY at what time:______________

If medicine is to be given "WHEN NEEDED", describe indications:______________________

How soon can it be repeated?______________Is child authorized to medicate self?______

List significant side effects:______________________________________

Length of time this treatment is recommended:______________________________

Other information:____

____

Date:____________________ ______________________________

(Physician's Signature)

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