Authorization for Physician Prescribed Medication
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 take the medicine(s) described below at school, supervised and/or assisted by authorized persons or permitted to self-carry and medicate self as 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)

☐ Check this box if you would like to request your child to carry their medication on them during the school day (subject to Executive Director approval).

Approved: _____ Declined: _____ _____
(Ececutive Director's Signature)