Authorization for Medications to be Taken During School Hours

The following section is to be completed by the PARENT:

_____
School

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 persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

_____ (____)_____ (____)_____
Date Parent/Guardian Signature Home Phone Emergency Phone

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

Name of Medicine
Form
Dose
If medicine to be given DAILY, at what time?
If medicine to be given "WHEN NEEDED" describe indications:
How soon can it be repeated?
Is child authorized to medicate herself/himself?
List significant side effects:
Length of time this treatment is recommended:

Other information:

_____

_____

_____

_____

Date: _____ _____
(Physician's signature)