AUTHORIZATION TO ADMINISTER MEDICATION DURING SCHOOL HOURS

The following section is to be completed by the parent:

Child's School:_____

Child's Name:

Last Name:_____ First Name:_____

Male_____ Female_____ Date of Birth:_____

Physician's Name:_____

Physician's Address:_____ City_____ St____ Zip_____

Physician's Phone:_____

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 my physician and myself (see below).

_____

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 is to be given DAILY, at what time?_____

If medicine is to be give 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:_____

_____ _____ _____

Physician's Signature Physician's Printed Name Date