

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

(SCHOOL NAME)

LAST NAME

FIRST NAME

SEX

DOB

I request that my child be assisted in taking the medicine(s) described below at school by an authorized person or permitted to medicate herself/himself as also authorized by my physician (see below)

Parent/guardian signature

DATE

HOME PHONE

EMERGENCY PHONE

DIAGNOSIS FOR WHICH THE MEDICATION IS GIVEN: _____

NAME OF MEDICINE:
FORM:
DOSAGE:
If Medicine is given DAILY, at what time?
If Medicine is given WHEN NEEDED, describe indications: -
How soon can it be repeated?
Is child authorized to medicate themselves?
List significant side effects:
Length of time this treatment is recommended: YEARLY

Other information: _____

Physician Signature

Date