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 _____ 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 me and my physician (see below).

Parent/Guardian Signature _____ Date _____

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:

_____

_____

_____

Physician's Signature _____ Date _____

REQUIREMENTS FOR DISPENSATION OF MEDICINE AT SCHOOL

All medications, including non-prescription drugs such as: Tylenol, Motrin, Benadryl, etc…, will not be administered during school hours unless it has been prescribed by your child's physician and this form has been completed. Medication must be brought to school in the original package or container with the child's name on it or attached. **If you have any questions regarding this policy, please consult your building principal or nurse.**