

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
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Physician _____

Name	Address	Telephone
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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). Information regarding the student's medication may be shared.

Date	Parent/Guardian Signature	Home Phone	Emergency Phone
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The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given: _____

Name of Medicine
Form
Dose
If medicine to 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? <input type="checkbox"/> yes <input type="checkbox"/> no
List significant side effects:
Length of time this treatment is recommended:
The student has the knowledge and the skills to safely possess and use an epipen or inhaler <input type="checkbox"/> yes <input type="checkbox"/> no
Other information/comments: _____ _____ _____

Date: _____

Physician signature (Required for: inhaler/epipen only or when medication is not in the original container)
Adopted: January 10, 2006