PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*. I understand that in the case of the absence of the school nurse, a designated person will carry and monitor the administration of the medications, including on field trips.

Signature(Parent or Guardian): _____

Telephone: Home _____ Work _____ Date _____ _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____ _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____ _____

Physician's Signature _____ Date:_____

Physician's Name : _____Phone:_____ _____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____Date:_____