PHYSICIAN'S REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

This section to be completed by the parent or guardian.

Name of Student _____ Birthdate_____

Student's Address _____

School District _____ School _____

Grade _____ Homeroom No. _____ Homeroom Teacher _____

PARENT/GUARDIAN AUTHORIZATION FORM

School personnel approved by the Board of Education are herewith authorized to administer the medication or procedure as instructed by the physician.

I request school personnel administer the medication as instructed and agree to:

1. Deliver the medication that is required for dispensation during school hours in the original container which was provided by the prescribing physician or licensed pharmacist
2. Deliver written notification (by the next school day) to the school by a physician if the medication, the dosage, or the procedure is to be changed or eliminated .

Parent/Guardian Signature _____ Date _____

Telephone No. During School Hours _____ Other Telephone No. _____

This section to be completed by the physician.

PHYSICIAN'S AUTHORIZATION AND INSTRUCTIONS

Physician's Name _____ Date _____

Physician's Phone _____ Alternate Number _____

Name of Medication to be given _____

Dosage _____

Time(s) Medication is to be given _____

Length of time Medication is to be given _____ to _____
(beginning date) (ending date)

Special instructions regarding medication _____

List adverse reactions that should be reported to physician _____

_____

Physician's Signature_____ Date _____

[Adoption date: August 6, 1991]

Revised: October 20, 1993
April 16, 1997