Townsend Schools
Physician Form for Administration of Medication

THIS FORM IS GOOD FOR ONE SCHOOL YEAR ONLY.

The following is to be completed by a health care provider (physician/nurse practitioner). No medication of any kind will be given to your child until this information is completed and returned to the school. Remember, all medication must be in a pharmacy-labeled container. If any changes in medication occur during the school year, a new form must be completed along with a new pharmacy/physician-labeled container, and returned to the school. Only one form for each medication is to be used.. Medication must be brought to school by a responsible adult. Please do not send medication by children. Over the counter medication must be brought to school in an original container.

TO BE COMPLETED BY PARENT:

Name of Student:_____ Date of Birth: _____

Grade: _____ Teacher: _____

I give permission for my child to be assisted by authorized persons in taking the medicine described below.

Date: _____ Parent/Guardian Signature: _____

Home Phone: _____ Work Phone: _____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis for which medication is given: _____

Name of medication: _____ Dosage: _____

Time(s) at which medication is to be given: _____

If to be given "when needed", describe symptoms: _____

How soon can it be repeated? _____

Possible side-effects and procedure to follow: _____

Physicians/Nurse Practitioner's Name (Print) _____

Physicians/Nurse Practitioner's Signature: _____

Date: _____ Phone: _____

(Office Staff: Completed Form Received On _____ by _____)