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)

_____ _____ _____
Health Care Provider's Name Address Telephone

I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime. 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).

_____ _____ _____ _____
Date Parent/Guardian Signature Home Phone Emergency Phone

The following is to be completed by the PRESCRIBER:

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:

Date: _____ Prescriber Signature: _____

Adapted: The American College of Allergists