AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Name of Student_____ Grade_____

Physician Authorization

Reason for medication:_____

Name of medication: _____ Dose: _____ Route: _____

Frequency/time of administration: _____

Duration: (week, month, indefinite, until end of school year, etc.) _____

Other specific instructions or information regarding this medication/administration: _____

_____

_____

Special side effects, contraindications, or adverse reactions to be observed: _____

_____

_____

_____ _____

Physician Signature Date

_____ _____

Address Phone

PARENT'S REQUEST/APPROVAL REQUIRED – PARENT IS TO COMPLETE SEPARATE FORM

Palmyra R-1 Schools
P.O. Box 151
Palmyra, MO 63461

Elementary School
Phone: 573-769-3736
Fax: 573-769-4113

Middle School
Phone: 573-769-2174
Fax: 573-769-4227

High School
Phone: 573-769-2067
Fax: 573-769-1013