AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT:

School: Northeast Bradford CHECK ONE: ☐ ELEMENTARY ☐ HIGH SCHOOL

Child's Name: ______________________________ Sex: _______ Date of Birth: _______________

Primary Health Care Provider's Name: ____

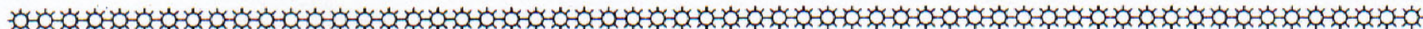
Provider's Address: ______________________________________ Phone #: _______________

Number/Quantity of Medication sent to school: ______________________________________

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate himself/herself as also authorized by me and my primary health care provider (see below)

Parent/Guardian Signature: ___________________________________ Date: _______________

Home Phone #: ____________________ Emergency Phone #: ____________________



The following section is to be completed by the PRIMARY HEALTH CARE PROVIDER:

Diagnosis for which medication is given: ______________________________________

Name of Medicine:	
Dose:	Form:
If medicine is to be given DAILY, at what time?	
If medicine is to be given WHEN NEEDED, describe indications:	
How soon can it be repeated?	
Is child authorized to medicate himself/herself?	
List significant side effects:	
Length of time this treatment is recommended:	
Other Information:	

PRIMARY HEALTH CARE PROVIDER'S SIGNATURE: ______________________________________

Date: ____________________