Peoria Heights Grade School
School Medication Authorization Form
School Year_____

Student's Name _____ Birth date _____

Address _____ Home Phone _____

Teacher _____ Grade _____ Parent/Guardian Name _____

Emergency Phone Numbers _____

Allergies _____

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To be completed by the student's physician

Name of Medication _____

Dosage _____ Frequency _____ Time to be given in school _____

Diagnosis Requiring Medication _____

Intended Effect of This Medication _____

Expected side effects, if any _____

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? **YES** **No**

Time Interval for Re-Evaluation _____

Other medications student is receiving _____

_____ _____
Physician's Name-Print Physician's Name-Signature

_____ _____
Phone- Office Date

_____ _____
Fax-Office Phone-Emergency

Further Instruction Remarks: _____

_____

PARENT TO COMPLETE THE BACK OF THIS SHEET!

Jc/2010