Authorization for Medication

Livingston County Schools
Livingston County Health Center, School Health Program

The following section is to be filled out the PARENT/GUARDIAN

Child's name_____ Date of Birth___/___/____

School_____ Grade_____

I request that my child be assisted in taking the medication(s) prescribed below by authorized persons. (Even if your child does not require assistance, such as with an inhaler, an authorization for medication must be filled out to enable your child to keep their medication with them during school hours.)

Date__/__/__ Parent guardian_____ Phone_____

The following section is to be filled out by the PHYSICIAN

Diagnosis for which medication is to be given:_____

Name of Medication_____

Form (pill, liquid, etc)_____ Dosage_____

If medication is to be given daily, at what time?_____

If medication is to be given "when needed" describe_____

_____

_____

List any significant side effects_____

Length of time treatment is needed_____

Other information_____

_____

_____

Date_____ Physician's Signature_____