

## H E A L T H   O F F I C E

### Authorization by Parent & Physician For Medication To Be Taken During School Hours

Child's Name \_\_\_\_\_

Sex \_\_\_\_\_ DOB \_\_\_\_\_ Physician's Name \_\_\_\_\_

Address & Telephone Number \_\_\_\_\_

I request that my child be assisted in taking the medication(s) described below at school by the authorized Person(s). The medication is to be furnished in the original container from the pharmacy.

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Date	Parent/Guardian Signature	Home Phone	Emergency Phone Number
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**The form below is to be completed by the Physician.**

Diagnosis for which medication is given \_\_\_\_\_

Name of Medication \_\_\_\_\_

Form \_\_\_\_\_

Dose \_\_\_\_\_

The medication is to be given DAILY, at what time? \_\_\_\_\_

If the medication is to be given "When Needed" describe criteria: \_\_\_\_\_

\_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_

Is child authorized to medicate self? (Inhaler or Bee Sting Kit Only) \_\_\_\_\_

List significant side effects: \_\_\_\_\_

Length of time this treatment is recommended: \_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_ Physician's Signature \_\_\_\_\_