

AUTHORIZATION FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

Last	Firs		Sex	Date of Birth
	0.11			
	School			Grade
Physician's Name I request that my child be assisted in tag at school by authorized persons as ord	Address aking the medicine lered by my physici	(s) described below an (see below).		Telephone
Date Parent/Guardian Signa	ature	Home Phone	Emergency	Phone
The following is to be completed by Diagnosis for which medication is being	the PHYSICIAN:			
Name of Medicine				
orm				
Dose				
If medication is to be given DAILY, at	what time?			
If medication is to be given PRN, how	often?			
How soon may the PRN medication be	repeated?			
Is this medication required to be admini	istered on class trip	s?		
List significant side effects:			······································	
Length of time medication is recommen	ided:			
Additional information:				
ate: Physician	2- 0:			