AUTHORIZATION FOR ALL MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS - School Year 2011-2012

Note: This includes "over the counter" and prescription medications

→ The following section is to be completed by the **PARENT**:

Child's Name: Last First ____________________ Sex ______ Date of Birth ____________________

Physician's Name Address ____________________ Phone Number ____________________

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 physician (see below).

Parent/Guardian Signature ____________________ Date ______

Home Phone: ____________________

Emergency Phone: ____________________

→ The following is to be completed by the **PHYSICIAN**:

Diagnosis for which medication is given:

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

Other Information:

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Physician's signature ____________________ date ______