# AUTHORIZATION FOR MEDICAITONS TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT:

______________________________________________________________

School

**Child's Name**______________________________________________

**Last** **First** **Sex** **Date of Birth**

**Physician** _________________________________________________

**Name** **Address** **Telephone**

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below). Information regarding the student's medication may be shared.

______________________________________________________________

**Date** **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

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

Diagnosis for which medication is given: ________________________________

| Name of Medicine |
|---|
| Form |
| Dose |
| If medicine to given DAILY, at what time? |
| If medicine to be given "WHEN NEEDED,"<br>Describe indications: |
| How soon can it be repeated? |
| Is child authorized to medicate herself/himself? ____ yes _____ no |
| List significant side effects: |
| Length of time this treatment is recommended: |
| The student has the knowledge and the skills to safely possess and use an epipen or inhaler _____ yes _____ no |
| Other information/comments:<br>______________________________<br>______________________________<br>______________________________<br>______________________________ |

**Date**: __________

______________________________

**Physician signature** (Required for: inhaler/epipen only or when medication is not in the original container)

**Adopted: January 10, 2006**