



Authorization for Medications to be Taken during School Hours (Sample Form)

The following section is to be completed by the PARENT:

School _____			
Child's Name: _____ (Last)	_____ (First)	_____ (Sex)	_____ (Date of Birth)
Health Care _____ Provider's Name	_____ Address	_____ Telephone	
<p>I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime. 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).</p>			
_____ Date	_____ Parent/Guardian Signature	_____ Home Phone	_____ Emergency Phone

The following is to be completed by the PRESCRIBER:

Diagnosis for which medication is given:
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 treatment is recommended:

Other Information:

Date: _____ Prescriber Signature: _____

Adapted: The American College of Allergists