Physician's Authorization of Medication for a Student While in School

2021-22

Full name of child to be medicated: ____

DOB: ____ GRADE ____

This is to certify that, in order to keep this child in optimum health and/or help maintain optimum performance at school, it is necessary that medication be given during school hours.

Name of medication (include trade name): ____

Medication is to be given in form circled: tablet ointment liquid capsule inhalation

Other: ____

Dosage amount to be administered during school hours: ____________________________________

Hour(s)/Day(s) medication to be administered: ____

Reason for medication: ____

Physician prescribing medication (print): ____

Physician phone number: ____

If this medication is on a PRN (as needed) schedule, please describe how the person administering medication is to determine when medication is needed: ____

____

Side effects (expected/predictable): ____

The child's parent/guardian knows of this request and is in full agreement that this medication will be administered as indicated. Should the student manifest any of the following symptoms caused by the medication, please discontinue administration and notify the parent/guardian or my office immediately:

____

____

Contraindications for administration of medication: ____

____

Physician's Name: ____________________________________PHONE: ______________________________
(PLEASE PRINT)

Physician's Signature (No Stamp)______________________________________ DATE:______________________