Marcus Whitman Central School District
Valley Elementary School Nurse's Office 554-4802 x 2
Gorham Intermediate School Nurse's Office 526-6351 x 2
Middle -High School Nurse's Office 554-6441 Fax 554-4810

Part I: To be completed by Parent/Guardian

I authorize the school medical personnel to see that my child, ________________________________,

receives the medication prescribed by ____ (See below)

____ _________________________
(Parent's /Guardian's Name --Please print) (Phone Number)

____ _________________________
(Parent's /Guardian's Signature) (Date)

Part II: To be completed by Physician

Diagnosis:____

____
(medication) (dosage) (route of administration) (time/frequency)

******Has been instructed in & understands the purpose & appropriate method & frequency of use & is permitted to carry the medication in the original container on his/her person as we consider him/her responsible*** **YES**_______ **NO**_________

If PRN, state frequency or indication: ____

Duration of treatment: ____

Possible side effects and adverse reactions: ____

Other recommendations: ____

____ ____________________ ____________________
(Physician's name—please print) (phone number) (fax number)

____ ____________________________
(Physician's signature) (date)

Please list all medications that your child is taking at home:______________________________