



## HEALTH OFFICE

### PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

NAME OF CHILD \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Condition for which the drug is being administered \_\_\_\_\_

Drug \_\_\_\_\_ Dose \_\_\_\_\_

Method of Administration \_\_\_\_\_

Time of Administration \_\_\_\_\_

Medication shall be administered from (date) \_\_\_\_\_ to (date) \_\_\_\_\_

Relevant side effects to be observed, if any \_\_\_\_\_

If there are side effects, plan for management \_\_\_\_\_

Is this a controlled drug? Yes \_\_\_\_\_ No \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_

PHYSICIAN'S ADDRESS \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### PARENT AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

I hereby request that the medication ordered by the physician for my child be administered by school personnel. I understand that I must supply the school with the medication in the original pharmacy bottle or the original over-the-counter container. I understand that medication must be delivered to school by an adult and that any medication not picked up one week beyond the close of school will be destroyed.

Parent Signature \_\_\_\_\_