MILL SPRINGS ACADEMY

Authorization for Prescription Medication

Date_____

Student's Name_____

I request that Mill Springs Academy, through its nurse or designee, administer medication to my child according to the physician's instructions. I understand that the school nurse will send the appropriate dose(s) of my child's medication on field trips to be given by my child's teacher.

_____ _____

Parent/Legal Guardian's Signature Phone Number

Physician's Statement

Name and strength of medication _____
Dosage to be given _____ Time to be given _____
Expected duration of administration _____
Possible side effects:

□ Headaches □ Restlessness □ Tics
□ Stomachaches □ Decreased Appetite □ Sedation
□ Other _____

Name and strength of medication _____
Dosage to be given _____ Time to be given _____
Expected duration of administration _____
Possible side effects:

□ Headaches □ Restlessness □ Tics
□ Stomachaches □ Decreased Appetite □ Sedation
□ Other _____

Name and strength of medication _____
Dosage to be given _____ Time to be given _____
Expected duration of administration _____
Possible side effects:

□ Headaches □ Restlessness □ Tics
□ Stomachaches □ Decreased Appetite □ Sedation
□ Other _____

_____
Physician's Signature

_____
Physician's Printed Name

_____
Phone Number (may attach a business card)

The school nurse, Ann Hartin, should be notified of all medication changes.