ST. GEORGE'S SCHOOL

Authorization to Administer Prescription Medication

To be completed by prescribing physician

Student Name: _____ Date of birth: _____

Diagnosis:_____

_____

_____

Medication(s) and dose: _____

_____

_____

Medication Allergies: _____

The School Physician is authorized to alter the medication, dose, and schedule for the benefit of the student.

Signed: _____, M.D. Date: _____

State License #: _____

Phone: _____

Fax: _____

This form is required by the Rhode Island Department of Health.
Complete only if the student is on medication.

Please duplicate this form if needed.

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