ALLEN EAST LOCAL SCHOOLS

MEDICATION and/or MEDICAL PROCEDURE AUTHORIZATION FORM

*Medication must be sent to school in original container as dispensed by physician or pharmacy.

Name of Student_____ Date of Request_____

Address_____Homeroom or Teacher_____

_____ Grade _____

Name of Medication:_____

Dosage (or procedure required): _____
(procedure must be on child's I.E.P.-if appropriate)

_____

_____

Times and Intervals Required:_____

_____

Possible Reactions which should be reported to the Physician:_____

_____

_____

Special Instructions-Including storage and sterile requirements:_____

_____

_____

Date Drug to Begin:_____

Date When Medication or Procedure no longer needed:_____

Physician's Signature_____

Date:_____ Telephone: _____

Parent/Guardian (s) Authorization:

I_____ authorize the school personnel to administer the medication
(Name of Parent/Guardian)
or procedure as instructed by the physician, and agreeing: (1) to deliver the medication to the school: (2) to notify the school if there is a change in physician: (3) to notify the school if the medication, the dosage or the procedure is changed or to be eliminated.

_____ _____

Signature of Parent or Guardian Date

gnature of those authorized to administer the medication or procedure.

Signature	Position
Signature	Position
Signature	Position
Signature	Position