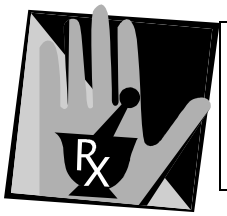

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

PARENT/GUARDIAN SECTION:

Student Name_____Date of Birth_____Gr. / Teacher____
Physician's Name _____
Address_____Phone:_____

I, _____request that my child _____ receive the medication described below during school hours by authorized persons.

Signature of Parent/Guardian_____Date _____
Home Phone_____Emergency contact_____

LEGAL PRESCRIBER SECTION:

DIAGNOSIS:_____
Medication / Dosage / Route _____

- DAILY Time of Administration:_____
- PRN Describe indication(s) for administration:_____
  _____
  Time interval for repeat dosage:_____

Start date_____End date_____
List significant side effects:_____
_____

Outline any restrictions the medication may have on the student's daily activities:
_____

Note other medications that may enhance, alter, or impact the effects of the ordered medication:_____
_____
Other information:_____
_____

Date:_____Signature of Legal Prescriber_____

A SEPARATE FORM IS REQUIRED FOR SELF-ADMINISTRATION