Central Greene School District

WCES Fax	724-852-1160
MBM Fax	724-627-0637
WCHS Fax	724-852-2090

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the **PARENT:**

Child's Name ______ Sex ______ Date of Birth ______

Physician's Name ______ Telephone Number ______

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate himself/herself as also authorized by me and my physician (see below).

Date ______ Parent/Guardian Signature ______ Home phone ______ Emergency Phone ______

The following section is to be completed by the **PHYSICIAN:**

Diagnosis for which medication is given: ______

Name of Medicine:
Form:
Dose:
If medication is to be given **DAILY,** at what time?
If medication is to be given "**WHEN NEEDED**", Describe indications:
How soon can it be repeated:
Is child authorized to medicate himself/herself?
List significant side effects:
Length of time this treatment is recommended:

Other information: ______

Date: ______ Physician's signature ______