DOVER SCHOOL DISTRICT
MEDICATION AUTHORIZATION

TO BE COMPLETED BY PARENT OR GUARDIAN: (please print)

Student's Name ____Sex: ______ Date of Birth ______

School ___________________________Grade ________Height (inches) ________Weight (lbs.) ___________

____
Primary Care Provider Name (MD, DO, PA, APN) Telephone Number

I request that my child be given the following medication described below at school by the school nurse.

____
Parent/Guardian Signature Date Telephone Number

TO BE COMPLETED BY THE STUDENT'S PRIMARY HEALTH CARE PROVIDER: (please print)

Diagnosis for which medicine is to be given: ____

Name of Medication: ____

Dosage: ___________________ Form (tablet, liquid) ___________________ Frequency: __________________

If medication is given **daily**, what Time: ____

If medicine is given **"PRN"** please specify: ____

Limitations: ____ How soon can it be repeated: ___________

List significant side effects: ____

Length of time medication is recommended: ____

Other information: ____

____
Primary Care Provider Signature Date Official Stamp