Lincoln Intermediate Unit 12
Leadership • Expertise • Innovation

PHYSICIAN'S REPORT – MEDICATION

Name of Child:

Name of Medication:

Purpose of Medication:

Description of Medication:

Date and Duration of Prescription:

Dosage:

Time of Dosage:

Special Instructions, if any (pills crushed, with water, after meals, etc.)

Possible reactions or side effects:

Procedure to follow if reaction/side effects are observed:

Person to contact:

Phone Number:

Special Storage required: (refrigeration, etc.)

Signature of Physician

Date

I hereby authorize the medication listed above to be administered to my child by the classroom teacher, school nurse, (or in certain emergency situation, the driver), if available. We do agree to hold the said employee harmless from any liability connected with the administration of medication and medically provided services at the times and in the manner set by the physician.

Parent(s) Signature

Date