Central Greene School District

WCES Fax 724-852-1160

WCHS Fax 724-852-1118

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

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

_____ _____ _____ _____

Child's Name grade school year 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).

_____

Parent/Guardian Signature Emergency Phone Date

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 carry/medicate self?
List significant side effects:
Length of time this treatment is recommended:

Other information: _____

Date: _____ **Physician's signature** _____