PS1 PLURALISTIC SCHOOL ONE

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

(To be completed by a licensed physician and parent or guardian for any over-the-counter or prescription medication) PLEASE PRINT LEGIBLY!

______________________ First and Last Name of Child	______________________ Date of Birth
______________________ Name of Medication	______________________ Purpose of Medication
______________________ Dosage Prescribed & Time Schedule	______________________ Dose Form (tablet or liquid)
______________________ Date of Prescription/Expiration Date medication will be necessary	______________________ Length of time this

Precautions, Special Instructions, Possible Adverse Effects, and/or Comments:____

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The child for whom this medication is prescribed is under my care.

______________________ Physician's Name (Printed)	______________________ Signature of Physician
______________________ Street Address	______________________ City, State, Zip Code
______________________ Telephone Number	______________________ Date (include year)

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I request that my child, (print) ______________________, who is in __________'s class, be assisted in taking the prescribed medication at school by authorized persons, in compliance with the school's policies and procedures.

______________________ Signature of Parent or Guardian	______________________ Date: (include year)