Authorization for Medications to be Taken During School Hours

LYNDHURST PUBLIC SCHOOLS

The following section is to be completed by the Parent:

Child's Name _____ _____ _____
Last First Sex Date of Birth

Physician's Name & Address _____

I request that my child be assisted in taking medications described below at school by authorized persons.

_____ _____ _____
Date Parent/Guardian Signature Home Phone

The following is to be completed by the physician: _____

Diagnosis for which medication is to be given: _____

_____

Name of Medication: _____

Form: _____

Dose: _____

If medication is to be given daily, at what times? _____

If medication is to be given when needed, describe indications: _____

How soon can it be repeated? _____

Is child authorized to take medication himself/herself? _____

List significant side effects: _____

_____

Length of time this treatment is recommended: _____

Other information: _____

_____

_____

Date: _____ _____

Physician's Signature plus MD STAMP

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