Hazelwood School District
"A Culture of High Expectations and Excellence!"

Dr. Nettie Collins-Hart, Ed.D Superintendent

PHYSICIAN AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS School Year 2025-26

School_____ Fax # _____

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

Child's Name (Last)_____(First) _____

Sex ____ Birthdate_____Physician's Name _____

Physician's Phone #_____Fax # _____

I am requesting that, during school hours, the school nurse or designated person administer this prescription medication ordered by authorized persons below. I give permission to the school nurse to destroy any medication remaining at the end of the school year if I do not pick it up.

Date:_____Parent Signature _____

Home Phone_____Emergency Phone _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN:

Reason for Medication _____

Name of Medication _____

Form of Medication _____Tablet/Capsule _____Liquid _____Inhaler _____Injection _____

Other (explain) _____

Instructions (Schedule and dose to be given at school) _____

Start (Date form received) _____ Other Date _____

Stop_____July 30, 2026 Other Date _____

_____For episodic/emergency events only

Restrictions and/or important side effects: None expected _____

Yes, (Describe) _____

Special Storage Requirements _____None _____Refrigerate _____Other (explain) _____

Please indicate if you have provided additional information _____on reverse side _____attachment

Date _____PHYSICIAN'S SIGNATURE_____

Address _____Phone _____