AUTHORIZATION FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT:

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

_____
School Grade

_____
Physician's Name Address Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as ordered by my physician (see below).

_____ _____ _____ _____
Date Parent/Guardian Signature Home Phone Emergency Phone

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is being given: _____

Name of Medicine
Form
Dose
If medication is to be given DAILY, at what time?
If medication is to be given PRN, how often?
How soon may the PRN medication be repeated?
Is this medication required to be administered on class trips?
List significant side effects:
Length of time medication is recommended:

Additional information: _____

_____

_____

Date: _____ Physician's Signature _____

CLHF #29 Rev. 8/11