



PRESCRIBED MEDICATION FORM

ADMINISTRATION OF PRESCRIBED MEDICATION FORM

Student _____ Grade _____
 Birthdate _____ School _____
 Name of Family/Agency _____ Home Phone _____
 Home address _____ Work Phone _____

REQUEST AND AUTHORIZATION

I, hereby, request and authorize the administration of the following prescribed medication for my child _____
 by non-medically trained staff at _____ school.

Date _____ Signature _____
 Name of student's pharmacist _____ Phone _____

<i>Medication Prescribed</i>	<i>Dosage</i>	<i>Side effects</i>
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- 1.
- 2.
- 3.

Please state duration of time to be covered by this parental and doctor's authorization (not to extend beyond the current school year) _____

Name of student's doctor _____ Phone _____

Doctor's signature _____

Other pertinent information _____

Note:

1. Families/Agencies are required to contact the Principal of the school if there is a change in medication and/or dosage.
2. A unit dosage system must be utilized.
3. This form is to be completed in quadruplicate (4 copies).
 - a) School
 - b) Family/Agency
 - c) Doctor
 - d) Pharmacist
4. It is expected that only the daily requirement will be sent to school unless other arrangements are made with the Principal.