PARENT/GUARDIAN AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by physician:

I request that my patient, as listed below, receive the following medications, including over-the-counter medications, homeopathic and herbal remedies, and vitamin supplements:

Name of Student: ____ Date of Birth: _____________

Diagnosis/Diagnoses: ____

Medications*	Dosage	Frequency/Time To be Taken	Duration of Treatment	Route of Administration	Possible Side Effects/ Adverse Reactions

Physician's Name: ____Phone: _______________________

Physician's Signature: ____ Date: ______________________

B. To be completed by parent or guardian:

I request that my child __________________________________Date of Birth ____________ receive the medications, including over-the-counter medications, homeopathic and herbal remedies, and vitamin supplements, as prescribed above by our physician. The medication is to be furnished by me in the properly labeled original container*. I understand that in the case of the absence of the school nurse, a designated person will carry and monitor the administration of the medications, including on field trips. The below plan has been reviewed with me.

Parent/ Guardian Name: ____

Signature (Parent/Guardian): ____

Home Phone: ______________________ Other Phone: ____________________ Date: ______________

*** Medication must be in original labeled container with specific orders and name of medication. Medication and refills must be brought to school by parent/guardian or responsible adult.**