

(PLEASE FILL OUT AND SIGN TOP PORTION ONLY FOR ASPIRIN OR TYLENOL)

Authorization for Medications to Be Taken During School Hours

Medication can only be given to a child in school with a written authorization from the parent and the attending physician. The following is to be completed by the parent:

Child's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

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Physician's Name	Address	Phone
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I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to self medicate himself/herself as also authorized by me and my physician. (See below)

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Date	Parent/Guardian Signature	Home Phone	Emergency Phone
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The following is to be filled out by the physician:

Diagnosis: _____
Name of Medication: _____
Route of Administration: _____
Dosage: _____
If medicine is to be given daily, at what time? _____
If medicine is to be given "WHEN NEEDED", describe indications: _____
How soon can it be repeated? _____
Is child authorized to self medicating himself/herself? _____
List significant side effects: _____
Length of time this treatment is recommended: _____
Date _____ Physician's Signature _____

Other Information: \_\_\_\_\_