AUTHORIZATION FOR MEDICATIONS
TO BE TAKEN DURING SCHOOL HOURS

This section to be completed by a parent/guardian:

School Year__________

Student’s Name__________________________________ Grade______________

Health Care Provider:_____________________________ Telephone______________

I request that my child be assisted, by an authorized person, in taking the medication described below:

Date ____________________ Parent/Guardian Signature ____________________ Telephone ________________

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The following is to be completed by the Health Care Provider:

Name of Medication:___________________________________________________________

Dose:_________________________ Time to be given:___________________________

If medication is to be given “WHEN NEEDED,” describe indications:

___________________________________________________________________________

How soon can it be repeated?_________________________________________________

Significant side effects:_______________________________________________________

___________________________________________________________________________

Other Information:___________________________________________________________

________________               ______________________________________________

Date ____________________ Health Care Provider Signature ____________________

NU 3.1-1 Parent/Physician Med Permissions 6/15