

School Authorization for Dispensing Medicine

Student's Name _____ Date _____

Teacher's Name _____ Room No. _____

Part I: To be completed by Parent/Guardian

I authorize the school medical personnel to see that my child, _____ ,
receives the medication prescribed by _____. (See below.)

(Parent's /Guardian's Name --Please print) (Phone Number)

(Parent's /Guardian's Signature) (Date)

Please list all medications that your child is taking at home:

Part II: To be completed by Physician

Diagnosis _____

(Medication) (Dosage) (Route of administration) (Time/Frequency)

If PRN, state frequency or indication: _____

Duration of treatment: _____

Possible side effects and adverse reaction: _____

Other recommendations: _____

Is this drug covered by the psychotropic drug law? ___ Yes ___ No

(Physician's Name --Please print) (Phone Number) (FAX Number)

(Physician's Signature) (Date)