(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: _____

_____

Physician's Name Address Phone

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)

_____ _____ _____ _____

Date Parent/Guardian Signature Home Phone Emergency Phone

_ _

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: _____
_____

8/07