

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

Re: _____ DOB: _____

This student has _____ for which the following medications have been prescribed for treating and preventing emergencies. This student has been trained in the use of these medications.

Medication	Dose	Route	Time

Please notify the parents if these do not relieve the students' problems.

Daytime phone number: _____

Evening phone number: _____

If you have any questions or concerns, please contact me at the numbers listed above.

_____ This student possesses enough skill and maturity to carry the medication and to use it under the general supervision of school personnel.

_____ This student's medication must be kept by school personnel and administered only with detailed and specific supervision.

Adverse effect that should be looked for: _____

Potential for abuse or addiction: _____

Comments: _____

Physician's name (print): _____

Physician's signature: _____

Parent's signature: _____ Date: _____