

## AUTHORIZATION FOR ADMINISTERING MEDICATION

I hereby give my permission for the nurse or school personnel to administer medication during the school day to my child, \_\_\_\_\_.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

Send medications on field trips?     Yes    No

Give medications on half days?     Yes    No

### PHYSICIAN'S INSTRUCTIONS

Name of Child: \_\_\_\_\_ Date of Order: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time to be given during school: \_\_\_\_\_

This medication:

\_\_\_\_\_ Has an end date of: \_\_\_\_\_

\_\_\_\_\_ Is for the entire school year.

\_\_\_\_\_ Is PRN.

\_\_\_\_\_ Morning dose may be given at school if forgotten at home.

Morning dose is \_\_\_\_\_

Can a reaction be expected? \_\_\_\_\_ If so, describe: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_