

AUTHORIZATION FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

The following s	section is to be complete	ed by the PAREN	Γ:		
Child's Name					
	Last	First		Sex	Date of Birth
School				Grade	
	ne y child be assisted in tal horized persons as orde	_	(s) described below		Telephone
Date	Parent/Guardian Signat	ture	Home Phone	Emergency	Phone
THE RESERVE TO THE PERSON OF T	is to be completed by thich medication is being				
Name of Medic	ine				
Form					
Dose					
If medication is	to be given DAILY, at	what time?			
If medication is	to be given PRN, how	often?			,
How soon may	the PRN medication be	repeated?			
Is this medication	on required to be admin	istered on class tri	ps?		
List significant	side effects:			3	
Length of time	medication is recommer	nded:	10		
Additional info	rmation:				
Date:	Physicia	n's Signature _			