

MEDICAL AUTHORIZATION FORM
Authorization for Adminstrating Medication
2010/2011 School Year

AUTHORIZATION FOR **EACH** MEDICATION TO BE TAKEN DURING SCHOOL HOURS
One of these forms must be completed for each medication your child may take during the school day. **This includes Tylenol / Aspirin / Advil / Benadryl / Tums (antacid).**

The following section is to be completed and signed by the PARENT (REQUIRED).

Child's Name: _____ Sex: ____ Date of Birth: _____

Physician's Name & Address: _____

Phone: _____

I request that my child be assisted by authorized persons to take the medicine described below as authorized by me AND my physician.

▶ Parent/Guardian signature (REQUIRED) Date

Home phone: _____ Emergency phone: _____

The following is to be completed by the PHYSICIAN; this includes Tylenol / Aspirin / Advil / Benadryl / Tums (antacid)

Name of medication: _____ Dose: _____

Times to be given: _____ Diagnosis: _____

Side effects: _____

Length of treatment (if applicable): _____

Other information: _____

▶ Physician's signature (REQUIRED) Date