



ALL SAINTS' ACADEMY
AUTHORIZATION FOR MEDICATION
2010-2011

The following section is to be completed by the PARENT:

School			
Child's Last Name	Child's First Name	Sex	DOB
Physician's Name		Street Address	Telephone

City, State and Zip Code			
I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as authorized by me and my physician (see below).			
Date	Parent/Guardian Signature	Home Phone	Emergency Phone

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____
Name of Medicine: _____
Form: _____
Dose: _____
If medicine is to be given at school, at what time? _____
If medicine to be given "WHEN NEEDED", describe indications: _____
How soon can it be repeated? _____
List significant side effects: _____

Length of time this treatment is recommended: _____

Other Information:

Date

Physician's/Nurse Practitioner's Signature

Place office stamp here.
