

## To the Physician & Parent/Guardian:

School policy permits selected school personnel to administer medication to students under physician's care who require medication during the school day. ALL medication received by the school must be packaged according to current pharmacy standards. The following information is required:

NAME OF CHILD:		D.O.B	GRADE:	
SCHOOL:		DIAGNOSIS:		
MEDICATION/DOSAGE/TI	ME TO BE GIVEN:			
INSTRUCTIONS FOR ADM	INISTRATION:			
SPECIAL CONDITIONS TO	OBSERVE:			
INDICATE ADDITIONAL M	IEDICATIONS CHI	LD IS RECEIVING:		
Signature of Physician	Pr	inted Name of Physician	Date	
Physician Address			Physician Phone	
		SCHOOL IN THE CONTAI PHARMACY OR PHYSICL		
	<u>DELED DI THE I</u>	<u>HARMACT OKTHISICI</u>		
To the Parent/Guardian: I authorize selected so (This section must b	*	lminister the above medication guardian)	n as prescribed.	
Signature of Parent/Guardian		Phone Number	Date	
To the School Nurse:				
Date Received	Date Started	Date Termir	nated	