HOLLAND PATENTCENTRAL SCHOOL

PARENT/GUARDIAN AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT SCHOOL

A. To be completed by the parent or guardian:

I request that my child ______________________________ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

I authorize ______________________________________, my child's teacher, to administer the following medication in situations where the school nurse or parent/guardian is unavailable. (such as class trips)

Signature (Parent or Guardian): ____

Telephone: Home ___________________ Work __________________ Date _____________

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____________________________________ DOB _____________________

Diagnosis: ____

MEDICATION	DOSAGE	TIME TO BE GIVEN	ROUTE

Duration of Treatment : Start Date _________________ End Date______________

Possible Side Effects and Adverse Reactions (if any): _______________________________

Physician's Signature _______________________________ Date: ______________________

Address: ____ Phone: _____________________

* Medication must be in original pharmacy labeled container with specific orders and name of medication.

* Medication and refills must be brought to school by parent, guardian or responsible adult.

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