AUTHORIZATION FOR MEDICATION / TREATMENT

Student's Name: _____ Grade: _____

Allergies: _____

_____

Diagnosis:_____

_____

_____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIME	SPECIAL INSTRUCTIONS/ SIDE EFFECTS

_____ _____

Physician's Name (Printed) Physician's Signature and Stamp

_____ _____

Physician's Office Number Date Completed

PARENTAL PERMISSION FOR MEDICATION / TREATMENT

My permission is given, for designated Clinic personnel, to administer to above prescribed medication to my child.

_____ _____ _____

Name of Parent / Guardian (Printed) Signature of Parent / Guardian Date Signed