0 1	1	TT .	1.1	•	•
Set	ากกไ	Hea	lth	Sei	rvices

PARENT AND HEALTHCARE PROVIDER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

To be completed by the Pare	nt or Guardian:						
	nild(Date of birth:) receive the cribed below by our physician. The medication is to be furnished by me in the						
properly labeled original container from the pharmacy*.							
Signature(Parent or Guardian	າ):						
Telephone: Home	Work	Date					
To be completed by the Priva	ate Healthcare Provi	der:					
I request that my patient, as listed below, receive the following medication:							
Name of Student		DOB					
Diagnosis:							
MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION				
Possible Side Effects and Adv	verse Reactions (if an	y):					
Healthcare Provider's Signatu	ıre	Date:					
Address: Phone:							
	I request that my child medication as prescribed belo properly labeled original comesignature(Parent or Guardian Telephone: Home To be completed by the Private I request that my patient, as It Name of Student Diagnosis: MEDICATION Possible Side Effects and Adv. Healthcare Provider's Signature for the property of t	medication as prescribed below by our physician. properly labeled original container from the pharmal Signature (Parent or Guardian): Telephone: Home Work To be completed by the Private Healthcare Provided I request that my patient, as listed below, received the Name of Student Diagnosis: MEDICATION DOSAGE Possible Side Effects and Adverse Reactions (if an Healthcare Provider's Signature	I request that my child				

This medication order is valid for the current school year and summer school as needed.

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.