Form 11-33-3-3

PRESTON COUNTY SCHOOLS

Authorization for Medications to be taken during School Hours
(For Long-Term Illness)

The following section is to be completed by the Parent/Guardian:

School:_____

Child's Name:_____ _____
(Last) (First) (MI) Birth Date

Physician's Name:_____ Phone:_____

I request that my child be assisted at school by authorized personnel in taking the medication(s) described below or that s/he be permitted to medicate himself/herself as also 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 the medication is prescribed:_____

_____

Name of Medicine:_____

Form of Medicine:_____

Dose:_____

If medicine is to be given daily, at what time(s)?_____

If medicine is to be given "When Needed", describe indications:_____

_____

How soon can it be repeated?_____

Is the student authorized to medicate himself/herself?_____

List significant side effects:_____

Length of time this treatment is recommended:_____

Other information:_____

_____

_____

_____
Doctor's Signature Date

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