Authorization for Medication

The following section is to be completed by the PARENT:

School _____ Grade _____

Child's Name _____ _____ _____

Last First Sex Date of Birth

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons as 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 medication is given:
Name of Medicine:
Form:
Dose:
If medicine is to be given at school, at what time?
If medicine is to be given "When Needed", describe indications:
How soon can it be repeated?
List significant side effects:
Length of time this treatment is recommended:

Other information:

Date: _____ _____

Physician's / Mid-level Practitioner's Signature

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Autorización para la Medicación

La sección siguiente será completada por el PADRE:

Escuela _____ Grado _____

Nombre del Niño _____ ____ _____
Apellido Primero Sexo Fecha de Nacimiento

Yo pido que mi niño se ayude en tomando la medicación(es) describió debajo en la escuela por personas autorizadas como autorizado por yo y mi médico (vea debajo).

_____ _____ (___)_____ (___)_____
Fecha Firma de Padre/Guardián Teléfono de Casa De Emergencia

La sección siguiente será completada por el MÉDICO:
The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given:
Name of Medicine:
Form:
Dose:
If medicine is to be given at school, at what time?
If medicine is to be given "When Needed", describe indications:
How soon can it be repeated?
List significant side effects:
Length of time this treatment is recommended:

Other information:

Date: _____ _____
Physician's / Mid-level Practitioner's Signature

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