St. Paul's Episcopal School
Medication Authorization Form

For medication which is to be administered on a regular or as needed basis through the school office. Please complete the top portion of the form below and **HAVE YOUR PHYSICIAN COMPLETE THE LOWER PORTION**. Return to the school office.

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child ______________________________, receive the medication as prescribed by our physician in the form below. The medication will be supplied by me. I further understand that the school secretary or other designated person will administer the medication.

Signature of Parent or Guardian: ____________________________________

Date: __________________________

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TO BE COMPLETED BY PHYSICIAN:

I request that my patient: ___________________________, receive the following medication:

Name of medication: ____

Prescribed dosage and route: ____

Time to be administered during school hours: _________________________________

Possible side effects and adverse reactions: _________________________________

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Diagnosis:

____

Other recommendations: ____

Signature of Physician: ____

Date: ______________, 20 __ Phone Number: ________________________