

DISPENSATION OF MEDICATION

SECTION A - To be completed by the parent

Child's name/birthdate

School district/school/classroom

Address

Telephone number

We (I) the undersigned, who are the parent(s)/guardian(s) of the above-mentioned child, request that the health care service, outlined below and prescribed by the physician, be provided to our child. We (I) authorize the school to appoint a qualified, designated person(s) to perform the prescribed treatment as directed by the physician. We (I) agree to notify the school personnel immediately if there is any change in either the child's treatment regimen or the authorizing physician.

Parent's/guardian's signature

Date

SECTION B - To be completed by the physician

Physician's printed name

Telephone number

Address

Name of the treatment/medication

Specific instructions for administration

Beginning date _____ Ending date _____

Adverse reactions that should be reported to the physician _____

Training necessary for lay personnel to administer treatment _____

Special storage instructions _____

Physician's signature _____

**MEDICATION MUST BE IN THE ORIGINAL CONTAINER IN WHICH IT WAS
DISPENSED. LIMIT AMOUNT TO ONLY THAT WHICH IS NEEDED!!**