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 and strength: _____

Prescribed dosage and frequency and route: _____

Time to be administered: _____

Date(s) to be given: _____

Possible side effects and adverse reactions: _____

_____

_____

Diagnosis:

_____

Other recommendations: _____

Signature of Physician: _____

Date: _____, 20 __ Phone Number: _____