

GASHLAND
PRESCHOOL

Authorization for Medications to be Taken During School Hours

The following section is completed by the PARENT:

School_____

Child's Name_____

Last	First	Sex	Date of Birth
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Physician's Name _____ Address _____ Telephone # _____

I give permission for exchange of verbal and written communication between the physician and the school director regarding my child's medication regime.

I request that my child be assisted in taking the medicine(s) described below at the school by authorized persons._____

Date	Parent/Guardian Signature
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The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given:_____

Name of Medicine (both prescription or non-prescription)

Form_____

Dose_____

If medication 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 Signature_____

