WASHINGTON EPISCOPAL SCHOOL

PHYSICIAN'S MEDICATION AUTHORIZATION FOR PRESCRIPTION MEDICATION

ONE MEDICATION PER FORM

For Completion by Parent(s)/Guardian(s)

Full Name of Student _____ School Year _____ Grade _____

Students should not carry or administer their own medication.

The School Nurse and faculty will be able to dispense this medication to your child at school or on field/study trips as directed by his/her physician.

- I understand that I must supply the faculty with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of the student, name of the physician, date, in the original box/container and directions for administration.
- Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered, as directed by my child's physician.
- I understand that the physician may be called if a question arises about my child's medication.

_____ _____
Signature of Parent Date

For Completion by Physician

1. Name and strength of medication _____
2. Reason for medication _____
3. Route of administration _____
4. Dosage of medication _____
5. Time of day medication is to be given _____
6. Date medication began _____ Date medication discontinued _____
7. Side effects _____
8. Additional Information (e.g. crush, dissolve) _____

_____ _____
Physician's Original Signature – (No Stamps) Date

_____ _____
Physician's Printed Name Physician's Telephone Number

_____
Physician's Address