Dr. Curtis Cain
Superintendent of Schools

Cheri Thurman
Assistant Superintendent
Student Services

Laura Smith
Director of Ancillary Services

AUTHORIZATION FOR PRESCRIPTION/OVER-THE-COUNTER MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

School: _____ **Fax Number:** _____

The following section is to be completed by the PARENT/GUARDIAN

Child's Name: (Last)_____(First)_____

DOB: _____

Physician's Name: _____

I request that my child be assisted in taking medicine(s) as prescribed by authorized persons below. I give permission to the school nurse to destroy any medication remaining at the end of the school year, if not picked up.

_____ _____
Parent Name Parent Signature

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis/Reason For Medication: _____

Name of Medication: _____

Form of Medication: ☐ PO ☐ Inhaler ☐ Injection ☐ Rectal
If PRN, Specify: When Indicated
(Signs/Symptoms)_____(Tylenol/Ibuprofen/Cold Remedies etc.)

_____

Time: _____ Frequency: _____

Start Date: _____ Stop Date: _____

Dosage: _____ For episodic/emergency events only: _____

Side Effects: (Describe) _____

Date:_____ Physician Signature_____

Physician Name (Please Print)_____

Address_____ Phone Number_____