

The Prout School

Authorization for Prescription Medications to be Taken During School Hours  
(PHARMACY - LABELED CONTAINERS ONLY)

Child's Name \_\_\_\_\_  
Last First Sex Date of Birth Grade

Physician's Name: \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

The following section is to be completed by the PARENT: I request that my child be assisted in taking the medicine(s) described below at school by the school-nurse teacher or permitted to medicate herself/himself as also authorized by me and my physician - \*see below.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Phone Emergency Phone \_\_\_\_\_

*The following is to be completed by the PHYSICIAN:*

Diagnosis for which medication is prescribed: \_\_\_\_\_

Name of medicine: \_\_\_\_\_ Dose \_\_\_\_\_

If medicine is to be give DAILY, at what time(s)? \_\_\_\_\_

If medicine 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? \_\_\_\_\_

\*Is child authorized to medicate herself/himself? \_\_\_\_\_

Self-medication applied only to inhalers, EpiPens and prescribed self-injected medication.

Other information \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_