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'sName:_____

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:_____