SAMPLE: DOVER SCHOOL DISTRICT
AUTHORIZATION FOR MEDICATION HEALTH SERVICES

_PARENT AUTHORIZATION (To be completed by the parent)

Student's Name _____ Grade _____

I request that my child be assisted in taking medication(s) described below at school and on field trips by authorized persons. I agree that all medications will be brought to school in original containers with prescriptive labels. *Please Note:* For Prescription Medications the school may only accept a 30 day supply.

Date _____ Parent Signature_____

To be completed by the parent

_____Over the Counter Medications (MUST be in original bottle)

Reason for medication _____

Name of Medication _____

Dose (Amount) _____

How soon can it be repeated? _____

Please check : ☐ School Year (or) ☐ Limited to _____ Days

_____ Prescription Medication

Name of medication _____

I request prescription to be given according to physician's order.

Prescription Medications (To be completed by the physician)

Diagnosis for which medication is prescribed _____

Name of Medication_____

Dose _____

Time _____

If medication is prn describe indications _____

Frequency _____

Significant side effects _____

Other information _____

_____

Please check: ☐ School Year (or) ☐ Limited to _____Days

_____ _____ _____

Date	Physician’s Signature	Phone No