



Student Services

"Learning Today, Leading Tomorrow"

Dr. Curtis Cain
Superintendent of Schools

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Student Services

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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 _____