Appendix iii

Administration of Prescribed Medication at School
Physician's Authorization

Student Information:

Name of Student: _____ D.O.B. _____

Address: _____ Telephone: _____

School: _____

Physician's Statement:

This is to advise that I have prescribed the administration of medication listed below:

Name of Medication		
Method of Administration	Oral	Injection
Dosage	Time(s) administered	
Possible side effects		
Action to be taken should such a reaction develop		
Allergies which should be noted (if applicable)		
Additional instructions (if applicable)		

Physician's Information:

Physician's Name:	Telephone
Address	
Physician's Signature:	Date:

Comments: _____

_____

_____

_____

This note is valid for the current school year only and must be renewed prior to or at the time of school opening in September if administration of medication is to be continued. If, at any time, the above information changes, a new note will be required.

NOTE: This medication is authorized in a dosage that does not exceed the recommended maximum in the Compendium of Pharmaceuticals and Specialists (C.P.S.).

_____ _____

Signature of Physician **Date**

Original to O.S.R. Copy to be kept with medication.