# Mayfield City School District

Gates Mills♦Highland Hts.♦Mayfield Hts.♦Mayfield Village

## Authorization for Medications to be Taken During School Hours

The following section is to be completed by the **PARENT**:

School: _____ Grade: _____ Year: _____

Student's Name: _____ _____ ___/___/___
Last First Sex Date of Birth

Address: _____
Street City Zip

I have read and understand the Mayfield City Schools' guidelines for giving medications. I request authorized school personnel to follow the medical instructions listed. I agree to see that the medication is delivered to the school; to notify if there is a change in physicians; to notify the school if the medication, dosage, or procedure is changed or discontinued. I give my consent to the school physician or school nurse to send and/or receive information related to my child's health, as they deem appropriate for the duration of this order as noted above.

___/___/___/ _____ (____) _____ (____) _____
Date Parent/Guardian Signature Home Phone Emergency Phone

The following is to be completed by the **LICENSED PRESCRIBER:**

| |
|---|
| Reason for which medication is given: |
| Name of Medicine: Brand: Generic: |
| Strength supplied: |
| Form: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other |
| Dosage to be given at school: |
| If medicine is to be given DAILY, at what time? |
| If medicine is to be given "WHEN NEEDED," describe indications: |
| How soon can it be repeated? |
| List significant side effects: |
| Length of time this medication is to be given: Start date: / / Stop Date: / / |
| Any restriction of school activities: e.g. sports, drivers' training, science labs, etc. |
| If self administering inhaler- additional forms are required. |
| Special storage requirements ☐ None ☐ Refrigerate ☐ Other |

(Licensed Prescriber's stamp)

_____
Licensed Prescriber's signature

Date: _____/_____/_____

Telephone: (_____) _____

Revised 8/00