

Authorization for Medications to be Taken During School Hours

School:	Grade:	_ Year:	
Student's Name:			/ /
Last	First	Sex	Date of Birth
Address:			
Street		City	Zip
I have read and understand the Mayfield authorized school personnel to follow the is delivered to the school; to notify if the medication, dosage, or procedure is chartor school nurse to send and/or receive in for the duration of this order as noted about the school in the duration of the school and school and school in the duration of this order as noted about the school in th	ne medical instructions listed. ere is a change in physicians; nged or discontinued. I give aformation related to my child	I agree to see that to notify the school my consent to the	t the medication ol if the school physician
//	gnature () Home Phone		ency Phone
Date Fareit/Quardian Sig	inature Home Fnone	Lillerg	ency Fhone
Reason for which medication is given: Name of Medicine: Brand: Strength supplied: Form: Tablet/capsule Liquid	☐ Inhaler ☐ Nebulizer	Generic:	
Dosage to be given at school:			
If medicine is to be given DAILY, at wh			
If medicine is to be given "WHEN NEE describe indications:	DED,"		
How soon can it be repeated?			
List significant side effects:			
Length of time this medication is to be g	given: Start date: / /	Stop Date:	/ /
Any restriction of school activities:	iven. Start date.	Stop Date.	, ,
e.g. sports, drivers' training, science labs	s, etc.		
If self administering inhaler- additional t	forms are required.		
Special storage requirements N	Jone Refrigerate	Other	
(Licensed Prescriber's stamp)			
(Licensed Prescriber's stamp)	Lice	nsed Prescriber's s	ignature
(Licensed Prescriber's stamp)		nsed Prescriber's s	ignature

Revised 8/00