



Mayfield City Schools

EVERY STUDENT. EVERY DAY.

Authorization for Medications to be Taken During School Hours *Only One Medication Per Form

The following section must be completed by the **PARENT**:

School:	Grade:	Year:
Student's Last Name:	First Name:	<input type="checkbox"/> M <input type="checkbox"/> F Date of Birth:
<p>I have read and understand the Mayfield City School guidelines for giving medications. I request authorized school personnel to follow the medication administration 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 if the medication, dosage, or procedure is changed or discontinued. I give my consent to the 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.</p>		
____/____/____ Date	_____ Parent/Guardian Signature	(____)_____ Home/Cell Phone
		(____)_____ Emergency Phone

The following section must be completed by the **LICENSED PRESCRIBER**:

Name of Medication: <input type="checkbox"/> Brand _____ <input type="checkbox"/> Generic _____	
Strength Supplied:	Reason for which Medication is Given:
Form: <input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer <input type="checkbox"/> Injectable <input type="checkbox"/> Other _____	
Dosage to be given at school:	
If dosage is to be given DAILY, at what time?	If dosage is to be given "WHEN NEEDED", describe indications:
How soon can it be repeated?	Length of time medication is to be given: _____/_____/_____ Start Date Stop Date
List significant side effects:	
Any restrictions of school activities: <input type="checkbox"/> Sports <input type="checkbox"/> Recess <input type="checkbox"/> Science Labs <input type="checkbox"/> Other _____	
Special Storage Requirements: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other _____	

(Licensed Prescriber's Stamp)	Licensed Prescriber's Printed Name: _____
	Licensed Prescriber's Signature: _____
	Date: ____/____/____
	Telephone Number: (____) _____

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***Please note a new form is required for every school year

Gates Mills • Highland Heights • Mayfield Heights • Mayfield Village