Dr. Terry Adams
Superintendent of Schools

Cheri Thurman
Assistant Superintendent
Special Services

Laura Smith
Director of Ancillary Services

Dee Hansen
Special Services Coordinator

*Recipient of the "**Distinction In Performance**" Award*
Every Year Since 2006

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_______________________________

I request that medicine(s) prescribed by the authorized physician below be administered my child according to physician directions . I give permission to the school nurse to destroy any medication remaining at the end of the school year if I do not pick it up.

Date:______________________

______________________________ ______________________________________
Parent Name Parent Signature

<u>THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN</u>

Diagnosis/Reason For medication____

Name of medication ______________________________OTC: ________________________________

Route/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___________________________________