



## MEDICATION INFORMATION

Please complete this form for any medication you wish to be administered by school personnel. All medication must be delivered to the school by a parent, guardian, or authorized adult.

**Prescription Medication Requirements:** All prescription medication must be in the original pharmacy container. A doctor's written instructions (attached or written below) are required for all prescription medication.

**Over the Counter Medication:** All over the counter medication must be in the original packaging. Parents must provide written instructions regarding dispensing.

DATE: \_\_\_\_\_ TEACHER'S NAME: \_\_\_\_\_  
STUDENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
PHYSICIAN'S NAME: \_\_\_\_\_  
PHARMACY PROVIDER: \_\_\_\_\_ RX # \_\_\_\_\_  
NAME OF MEDICATION: \_\_\_\_\_

**I HEREBY REQUEST AND AUTHORIZE SCHOOL PERSONNEL FROM THE SCHOOL LISTED BELOW TO ADMINISTER HIS/HER PRESCRIBED MEDICATION AS DIRECTED BY OUR DOCTOR.**

\_\_\_Alaiedon Elementary \_\_\_Harvey Ed. Center \_\_\_North Aurelius Elementary \_\_\_Steele Elementary

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_  
DAYTIME PARENT/GUARDIAN PHONE NUMBER: \_\_\_\_\_

### DOCTOR'S ORDERS

You are hereby directed to give to: \_\_\_\_\_  
(Name of child)  
his/her medication \_\_\_\_\_ in the amount of \_\_\_\_\_  
daily, before lunch or daily, after lunch or as follows: \_\_\_\_\_  
(Special instructions)  
for \_\_\_\_\_  
(Duration)

Possible side effects: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_ Telephone #: \_\_\_\_\_