Authorization to Administer <u>PRESCRIPTION</u> Medication by School Personnel
Stanley-Boyd Area Schools

_____ _____
Name of Student Date of Birth

_____ _____
Homeroom Teacher Grade

<u>Parent Consent</u>

I hereby give my permission to the principal/designee to give the medication or perform the procedure to my child according to the written instructions of the doctor as shown below. I also hereby agree to give my permission to the school nurse to contact my child's physician.

I agree to notify the school at the termination of this request or when any change in the below orders is necessary.

_____ _____ _____ _____
Date Parent/Guardian Signature Home phone Work phone

<u>Physician</u> complete this section:

This is to certify that _____(student) identified above is being attended and treated by me. It is essential that he/she be given the following medication in the dose indicated during school hours.

Name of physician prescribing medication _____ _____
Print physician name here Phone number

Name of medication_____ Reason for medication_____

Dosage and route_____

Hour(s) to be given in school_____

Possible side effects_____

Length of time to be given_____

_____ _____
Signature of physician Date

Note: It is the parent's responsibility to see that the school personnel receive this authorization. No medication will be given at school without signed consent of parent.