

**PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF
MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES**

A. To be completed by the parent or guardian:

I request that my child _____ DOB _____ receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

PLEASE CHECK AND INITIAL:

I authorize an Island Trees staff member/chaperone to administer the following medications during field trips to my self directed child. (as determined by school nurse and parent). _____

Signature (Parent or Guardian):

Telephone: Home _____ Work _____ Date _____

B. To be completed by physician:

I request that my patient, as listed below, receive the following medication:

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _____ Date: _____

Address: _____ Phone: _____

If applicable, child may self carry prescribed inhaler.

Physician's Signature _____ Date: _____

- * Medication must be in original pharmacy labeled container with specific orders and name of medication.
- * Medication and refills must be brought to school by parent, guardian or responsible adult.