

ALEXANDER LOCAL SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

PART A: TO BE COMPLETED BY THE PHYSICIAN

NAME OF STUDENT _____ DOB _____

STUDENT ADDRESS _____

STUDENT SCHOOL _____ CLASS _____

NAME OF MEDICATION _____

DOSAGE AND ROUTE OR METHOD OF ADMINISTRATION _____

TIMES REQUIRED TO DISPENSE MEDICATION _____

DATE ADMINISTRATION OF MEDICATION IS TO BEGIN _____

DATE ADMINISTRATION OF MEDICATION IS TO END _____

POSSIBLE SEVERE REACTION, WHICH SHOULD BE REPORTED TO THE PHYSICIAN _____

SPECIAL INSTRUCTIONS, INCLUDING STERILE CONDITIONS AND STORAGE REQUIRMENTS _____

PHYSICIAN'S NAME AND ADDRESS _____

PHONE NUMBERS, INCLUDING EMERGENCY NUMBER (S) _____

SIGNATURE OF PHYSICIAN _____

PART B: TO BE COMPLETED BY THE PARENT OR GUARDIAN

I request authorized school personnel to follow the medical instructions requested in PART A. I agree to see that the medication is delivered to the school; to notify the school if there is a change in physicians; and to notify the school if the medication, dosage, or procedure is changed or eliminated. I agree to comply with Alexander Local Schools' Board policy on the Administration of Medication to Students.

DATE _____ SIGNATURE _____

_____ Parent or Guardian