



Health Office

TEL. & FAX: (203) 302-3863

PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Name of Child _____ Date of Birth _____

Condition for which the drug is being administered _____

Drug _____

Dose _____

Method of Administration _____

Time of Administration _____

Medication shall be administered from _____ to _____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? _____

Physician's Name _____

Address _____

Physician's Signature _____ Date _____

Medication shall be administered from April through June

PARENT AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

I hereby request that the medication ordered by the physician for my child be administered by school personnel. I understand that I must supply the school with the medication in the original pharmacy bottle or the original over-the-counter container. I understand that medication must be delivered to school by an adult and that any medication not picked up one week beyond the close of school will be destroyed.

Parent's Signature _____



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PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS

Name of Child _____ Date of Birth _____

Allergies: _____ Other Medications: _____

ADVIL 200mg _____ **Reason:** Headache, fever, muscle aches, menstrual cramps
Dosage: 1 tab _____ 2 tabs _____
p.o. every 6 hours as needed
Do not administer within 4 hours of Tylenol

TYLENOL 325 mg _____ **Reason:** Headache, fever
Dosage: 1 tab _____ 2 tabs _____
p.o. every 4 hours as needed
Do not administer within 6 hours of Advil

BENADRYL 25 mg _____ **Reason:** Allergy Symptoms
Dosage: 1 tab _____ 2 tabs _____
p.o. every 4 hours

THROAT LOZENGES _____ **Reason:** Sore throat, dry cough
Dosage: 1 lozenge every _____ hour(s)

ANTACID _____ **Reason:** Relief of heartburn or upset stomach
Dosage: 1 tab _____ 2 tabs _____

OTHER OTC MEDICATION:
Med: _____ Reason: _____
Dosage: _____

Physician's Name _____

Address _____

Physician's Signature _____ Date _____

Medication shall be administered from April through June

PARENT AUTHORIZATION FOR ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL
I give the school permission to administer the above medications during school hours as needed.

Parent's Signature _____ Date _____