



# 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 January through March***

## 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 \_\_\_\_\_



# Health Office

TEL. & FAX: (203) 302-3863

## 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 January through March**

**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 \_\_\_\_\_