Eagle Hill School
LEARNING. TRANSFORMED.

HEALTH OFFICE

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 (date) _____to (date) _____

Relevant side effects to be observed, if any _____

If there are side effects, plan for management _____

Is this a controlled drug? Yes _____ No _____

PHYSICIAN'S NAME _____

PHYSICIAN'S ADDRESS _____

PHYSICIAN'S SIGNATURE _____ DATE _____

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 Signature _____