Waynesburg Central Elementary School

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Waynesburg, Pennsylvania 15370-8281
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AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT:

____
School

Child's Name ______________________ ______ __________
Last First Sex Date of Birth

______________________________ ______________
Physician's Name Telephone

I request that my child be assisted in taking the medicine(s) described below at school by authorized person or permitted to medicate herself / himself as also authorized by me and my physician (see below).

______ ________________________ ____________ ____________
Date Parent / Guardian Signature Home Phone Emergency Phone

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The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: ______________________________

Name of Medicine:
Form:
Dose:
If medication to be given DAILY, at what time?
If medication to be given "WHEN NEEDED", describe indications:
How soon can it be repeated?
Is child authorized to medicate herself / himself?
List significant side effects:
Length of time this treatment is recommended:

Other Information: ______________________________

Date: __________ Physician's Signature: ______________________