The Titusville Academy

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

The following section is to be completed by the **PARENT/GUARDIAN**:

Student's Name	DOB	Grade	Homeroom
_____	_____	_____	_____

I request that my child be given the medication listed below as directed by the physician at school.

Date	Parent/Guardian Signature	Telephone
_____	_____	_____

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____

Name of medications: _____ Dose: _____

_____ Time Administered: _____

If medicine is to be given "WHEN NEEDED", describe indications: _____

_____

How soon can PRN medicine be repeated? _____

List significant side effects: _____

Any restrictions or limitations: _____

Date prescribed: _____ Date to be discontinued: _____

PLEASE CHECK THE APPROPRIATE OPTION

RE: CLASS TRIPS

_____ **YES**, the prescribed dose can be withheld on the day of the class trip.
_____ **YES**, the time to be given can be adjusted with the parent/guardian.
_____ **NO**, this medication must be given to the child at the scheduled time.

I verify that this child is free from contagion and this medication is necessary for the student to fully participate in the school education plan.

PHYSICIAN'S SIGNATURE	DATE
_____	_____

(Print) Physician's Name	Address	Telephone Number
_____	_____	_____

This form must be completed for all medication, prescribed and over the counter. Medications are to be brought to school by the parent in the original container, labeled appropriately by the pharmacy. All medication will be kept in a locked storage area. Authorization for Administration of Medication in School Form must be completed for each school year.

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