Dr. Terry Adams
Superintendent of Schools

Cheri Thurman
Assistant Superintendent
Special Services

Laura Smith
Director of Ancillary Services

Dee Hansen
Special Services Coordinator

*Recipient of the "**Distinction In Performance**" Award*
Every Year Since 2006

AUTHORIZATION FOR PRESCRIPTION/OVER-THE-COUNTER MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

School _____ Fax Number_____

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

Child's Name (Last)_____(First)_____

DOB_____

I request that medicine(s) prescribed by the authorized physician below be administered my child according to physician directions . I give permission to the school nurse to destroy any medication remaining at the end of the school year if I do not pick it up.

Date:_____

_____ _____
Parent Name Parent Signature

THE FOLLOWING SECTION IS TO BE COMPLETED BY THE PHYSICIAN

Diagnosis/Reason For medication_____

Name of medication _____OTC: _____

Route/Form of medication ____PO _____inhaler ____injection __rectal

if PRN, specify: When indicated (signs/symptoms)_____ (Tylenol/Ibuprofen/Cold Remedies, etc.)

Time: _____ Frequency: _____

Start Date: _____ Stop Date: _____

Dosage: _____ For episodic/emergency events only: _____

Side effects: (Describe)_____

Date:_____ Physician Signature_____

Physician Name (Please Print)_____

Address_____ Phone Number_____