Billings

Authorization for Administration of Medication* at School

*Including all over the counter drugs, such as ibuprofen and acetaminophen.

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

Student's Name _____

Health Care Provider's Name _____

Health Care Provider's Phone _____

I request that authorized persons at school assist my child in taking the medicine described below. I also give my permission for exchange of information between the school staff and the health care provider.

Date _____ Parent/Guardian Signature _____

Home Phone _____ Emergency Phone _____

The following section must be completed by the HEALTH CARE PROVIDER:

I have determined that the medication named below is advisable during the school day.

Diagnosis _____

Name of Medicine _____ Dose _____

____ Tablet/Capsule ____ Liquid ____ Inhaler ____ Epi Pen

If medicine is to be given DAILY, at what time? _____

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

_____

How soon can it be repeated? _____

Length of time this treatment is recommended: _____

Possible side effects: _____

Emergency procedure in case of serious side effects: _____

Additional information: _____

_____

Date _____ Health Care Provider's Signature _____