SHARON PUBLIC SCHOOLS

Authorization for Dispensing Medication in School

To be completed by Physician

I request that my patient receive the following medication:

Student's Name _____ Grade ___ Diagnosis _____

Name of medication _____Route of administration _____

Dose of medication _____Time / Frequency _____

If PRN, please state frequency or indication _____

Duration of treatment _____ Possible side effects or adverse reactions
_____

Other recommendations _____

Has this student been instructed in the use of his/her Inhaler or Epi-Pen? Should this student be permitted to carry his/her Inhaler or Epi-Pen?

YES _____ NO _____ /YES _____ NO _____

Physician's name (printed) _____

Date _____

Signature _____ Phone number _____

To Be Completed By Parent :By signing below, I understand that this information may be shared with the appropriate school personnel, including administrators and employees who need to be informed about this medical issue.

I authorize the school nurse to see that my child _____ receives the medication prescribed by _____ .

Please allow my child to carry his/her inhaler _____ or Epi-Pen _____ .

Signature of Parent or Guardian _____

Home Phone _____ Work Phone _____

Please list all medications that your child is currently taking.
_____

_____

_____