

# THE PROUT SCHOOL

## Authorization for Medications to be Taken During School Hours (PHARMACY-LABELED CONTAINERS ONLY)

Child's Name \_\_\_\_\_  
Last First Sex Date of Birth Grade

Physician's Name/Address \_\_\_\_\_  
Telephone # \_\_\_\_\_

The following section is to completed by the PARENT:

I request that my child be assisted in taking the medicine(s) described below at school by the school nurse 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 is to completed by the PHYSICIAN:

Diagnosis for which medication is prescribed:

Name of Medicine: \_\_\_\_\_ DOSAGE: \_\_\_\_\_

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? \_\_\_\_\_

List of significant side effects \_\_\_\_\_

Length of time this treatment is recommended? \_\_\_\_\_

Is the child authorized to medicate herself/himself? \_\_\_\_\_

Self-medication applies ONLY TO INHALERS, EPI-CENS, AND PRESCRIBED SELF INJECTED MEDICATION.

Other Information: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_  
Physician's Signature \_\_\_\_\_