West Harvey-Dixmoor School District 147

Authorization and Permission for Administration of Medication

(A separate form is required for each medication.)

Name of Student _____ Birthdate _____

City _____ Zip _____ Home/Cell phone _____

Date: _____ School: _____

PHYSICIAN AUTHORIZATION:

Medication/Health Care Treatment _____ Dosage _____ Time to be administered _____

Intended effect of this medication _____ Other medications student is taking _____

Expected side effects, if any _____

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects.

Administration instructions

_____

_____

Phone Number of Physician _____ Signature of Physician _____ Date _____

Address of Physician _____ Print Name of Physician _____ Date _____