

PULASKI COUNTY SCHOOLS
Authorization for Medications to be taken at School

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

Child's Name:

Last	First	MI	Sex	Birthdate
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School	Teacher	Student ID#	Medication Allergies	
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Physician's Name	Address	Telephone		

I request that authorized school personnel assist my child when taking the medicine(s) described below while at school. I authorize the school to contact my child's physician or designee about this prescribed medication. I give my consent for the school nurse to share information regarding this medication with Pulaski County School personnel who assist with my child's care while at school.

Date	Parent/Guardian Signature	Telephone #	Emergency Phone
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The following is to be completed by the **PHYSICIAN** for all medications*.

Diagnosis or Condition being treated:	
Name of Medicine:	
Route:	
Dose: **	
If medicine to be given DAILY, at what time?	
If medicine to be given "WHEN NEEDED," describe indications:	
How soon can it be repeated?	
List significant adverse side effects/serious reactions:	
Length of time this treatment is recommended:	

Other Information: _____

Date: _____ Physician's Signature: _____

* **ANY** medication that is to be administered at school must be brought to school by a parent or guardian. **NOT** the child. Special situations should be discussed with the principal.

** State law requires notification of the physician of **ANY REQUEST** to withhold, discontinue or change the dose or schedule of a medication. Changes **REQUIRE** that a new authorization form be completed. Any discontinued medications not picked up within two weeks will be destroyed.

Adopted: April 13, 2000
 Revised: May 17, 2011