WARREN COUNTY TECHNICAL SCHOOL

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PARENTAL AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTERING STUDENTS MEDICATION

A. To be completed by the Parent/Guardian:

I request that my child_____________________________ in grade______ receive the medication as prescribed below by our physician. The medication is to be provided by me in the properly labeled original container from the pharmacy. I understand that the school nurse will administer the medication.

Signature of Parent/Guardian____

Address____

Telephone number____ Date________________

B. To be completed by the Physician:

I request that my patient, listed below, receive the following medication:

Name of pupil____ Age________________

Diagnosis____

Name of medication____

Prescribed dosage and means of administering____

____

Time to be taken during school hours____

Expected duration of treatment____

Possible side effects and adverse reactions (if any) _____________________________________

____

Other recommendations____

____

Warren County Technical School does not discriminate on the basis of race, color, national origin, sex, disability, religion, sexual orientation or age in its education programs and activities, including admission to or employment in such programs or activities.

PHYSICIAN NAME (PLEASE PRINT) ____

Phone____

Physician's signature____