

**AUTHORIZATION TO DISPENSE, MONITOR AND TRANSPORT PRESCRIPTION MEDICATIONS
and MONITOR MEDICAL DIAGNOSES**

I. This section to be completed by the child's ATTENDING PHYSICIAN:

My patient, _____, is prescribed the following medication(s) and dosages:

Printed Name

Please also indicate the **frequency** for each dosage ... **"E" for EVERYDAY** or **"S" for SCHOOL DAYS ONLY**

#	Name of Medication	Dosage	When Taken	Frequency	How long has student taken this medication
1					
2					
3					
4					
5					

Diagnosis: _____

Restrictions: _____

Printed Name of Attending Physician Signature of Attending Physician Telephone Number Date

II. This section to be completed by PARENT/GUARDIAN: _____ has my permission to receive the medication(s) listed above while at school, according to the standard policies. I understand that this information will be kept confidential and will be given to others at SMA only when needed for the care of my child. All medications must be delivered to the Infirmary in their ORIGINAL containers.

Printed Name of Parent/Guardian Signature of Parent/Guardian Relationship to Student Date

PARENTAL PERMISSION TO TRANSPORT MEDICATION

As the parent or guardian of _____, I give permission for this student to personally transport his/her medications for: _____ Vacations/Holidays _____ Long Leave Weekends _____ Traveling off Campus
