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

____ ____________________
Parent/Guardian Signature Date