SEDALIA #200 SCHOOL DISTRICT

PRESCRIPTION AND OVER THE COUNTER MEDICATION AUTHORIZATION

Physician Order

Student Name: _____ Diagnosis: _____

The following medications should be given during the school day.

Medication	Dose	Route	Time
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

List possible side effects for each medication:

_____

_____

_____

Print Physician Name:_____ Date_____

Physician Signature: _____

Parent Authorization

I request and authorize the school nurse and trained school personnel to administer the above medication(s) as prescribed by my child's physician.

I request and authorize the above medication to be administered during field trips during the current school year.

Print Name: _____ Date _____

Signature of parent or guardian: _____