EATON COMMUNITY SCHOOLS

AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT/GUARDIAN:

Child's Name_____ _____ Date of birth:_____
Last First Sex

Child's Address_____

Building_____ Grade level_____ Teacher_____

Physician's Name_____Telephone_____

Address_____

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or that he/she be permitted to medicate him/herself as also authorized by me and our physician.

_____ _____ _____ _____
Date Parent/guardian signature Home Phone Emergency Phone

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given_____

Name of medication_____

Form_____

Dose_____

Known medication, food and/or other allergies:_____

_____

If medication is to be given DAILY, at what time?_____
(NOTE: EATON COMMUNITY SCHOOLS WILL DISPENSE "NOON" MEDICATION FOR ONE-HALF HOUR DURING EACH BUILDING'S LUNCH PERIOD)

If medication is to be given "WHEN NEEDED" describe indications:_____

_____

How soon can it be repeated?_____

Is child authorized to medicate him/herself?_____

List significant side effects_____

Duration of treatment: _____, 20___ to _____, 20___.

Other information:

_____ _____
Date Physician's signature