AUTHORIZATION FOR MEDICATION ADMINISTRATION

Bottineau Public School School procedure requires a physician's or dentist's written order and parents or guardian's authorization for administration of medication. This includes prescription and over the counter medications. Medications must be in a properly labeled pharmacy prepared container or in the original bottle.

Name of Child_____ Date of Birth _____

PHYSICIAN'S OR DENTIST'S ORDER:

Medication:_____ Dose:_____ Route:_____

Time/Frequency: _____ Continue Until: _____

Reason for Medication: _____

Special Instructions: _____

Side Effects: _____

PHYSICIAN'S OR DENTIST'S NAME: _____

ADDRESS: _____ TELEPHONE #: _____

Physician's or Dentist's Signature: _____

Date: _____

AUTHORIZATION BY PARENT/GUARDIAN

Date: _____

To School Personal:

I hereby request that the above medication, ordered by the physician/dentist for my child, _____, be administered by authorized personnel. I understand I must supply the school with the child's medication in the original container or properly labeled pharmacy container. I understand that any remaining medication will be destroyed if it is not picked up by the last day of school by parent/guardian. I also give the nurse and or principal permission to contact my child's physician.

Parent Signature: _____

Relationship to child:_____