

**MEDICAL AUTHORIZATION FORM**  
**Authorization for Administrating Medication**  
**2008/2009 School Year**

AUTHORIZATION FOR **EACH** MEDICATION TO BE TAKEN DURING SCHOOL HOURS  
One of these forms must be completed for each medication your child may take during the school day. **This includes Tylenol / Aspirin / Advil / Benadryl / Tums (antacid).**

The following section is to be completed and signed by the PARENT (REQUIRED).

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_ Date of Birth: \_\_\_\_\_

Physician's Name & Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I request that my child be assisted by authorized persons to take the medicine described below as authorized by me AND my physician.

\_\_\_\_\_  
▶ Parent/Guardian signature (REQUIRED) Date

Home phone: \_\_\_\_\_ Emergency phone: \_\_\_\_\_

The following is to be completed by the PHYSICIAN, this includes Tylenol / Aspirin / Advil / Benadryl / Tums (antacid)

Name of medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Times to be given: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Side effects: \_\_\_\_\_

Length of treatment (if applicable): \_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_  
▶ Physician's signature (REQUIRED) Date