JLCD-E

AUTHORIZATION FOR MEDICAITONS TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the PARENT:

School

Child's Name_____
Last **First** **Sex** **Date of Birth**

Physician _____
Name **Address** **Telephone**

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below). Information regarding the student's medication may be shared.

_____
Date **Parent/Guardian Signature** **Home Phone** **Emergency Phone**

The following is to be completed by the **PHYSICIAN**:
Diagnosis for which medication is given: _____

Name of Medicine
Form
Dose
If medicine to given DAILY, at what time?
If medicine to be given "WHEN NEEDED," Describe indications:
How soon can it be repeated?
Is child authorized to medicate herself/himself? ____ yes _____ no
List significant side effects:
Length of time this treatment is recommended:
The student has the knowledge and the skills to safely possess and use an epipen or inhaler _____ yes _____ no
Other information/comments: _____ _____ _____ _____

Date: _____ _____

Physician signature (Required for: inhaler/epipen only or when medication is not in the original container)