Bristol Borough School District
Authorization for Medication Taken During School Hours

School____

Student's Name:____________________________ Date of Birth______________

Physician's Name___________________________ Address__________________

Telephone Number__________________________ FAX Number____________

I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime. I request that my child be assisted in taking 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).

____________	________________________	____________	____________
DATE	PARENT/GUARDIAN SIGNATURE	HOME PHONE	EMERGENCY #

The following is to be completed by the Physician:

Diagnosis for which medication is given:____________________________________

Name of Medicine:____

Dose:______________________________ Frequency:______________________

Route:_____________________________

Start Date:___________________________ Stop Date:______________________

Is child authorized to medicate herself/himself?__________________________

Comments/Additional
Information:____
____
____

Date:_____________ Prescriber Signature:______________________________