Presbyterian Day School
BUILDING BETTER BOYS

Authorization For Prescription Medications

The following section is to be completed by the PARENT:

Student's Name________________________ ___________________ ________________________
Last First Date of Birth

Grade____________________ Teacher____

Physician's Name________________________________ Physician's Phone #_____________________

Pharmacy Name__________________________________ Pharmacy Phone #______________________

I have read the form stating the "Procedures for the Distribution of Medication." I request that my child receive assistance from authorized persons in taking the medication described below.

_____________________ ______________________________________ _____________________
Date Parent/Guardian Signature Home Phone

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: ____

Name of medication: ____

Form:____Dose:_________________________________

If medication is to be given "daily," at what time? ____

If medication is to be given "when needed," describe indications:_____________________________

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How soon can it be repeated? ____

Is child authorized to medicate himself? ____

List significant side effects: ____

Length of time this treatment is recommended:____

Other Information:

__________________________________ __________________________________
Date Physician's Signature