PULASKI COUNTY SCHOOLS
Authorization for Medications to be taken at School

The following section is to be completed by the **PARENT:**
Child's Name:

_____

Last First MI Sex Birth date

_____

School Teacher Student ID# **Medication Allergies**

_____

Physician's Name Address Telephone

I request that authorized school personnel assist my child when taking the medicine(s) described below while at school. I authorize the school to contact my child's physician or designee about this prescribed medication. I give my consent for the school nurse to share information regarding this medication with Pulaski County School personnel who assist with my child's care while at school.

_____

Date Parent/Guardian Signature Telephone # Emergency Phone

The following is to be completed by the **PHYSICIAN** for all medications*.

Diagnosis or Condition being treated:	
Name of Medicine:	
Route:	
Dose: **	
If medicine to be given DAILY, at what time?	
If medicine to be given "WHEN NEEDED," describe indications:	
How soon can it be repeated?	
List significant adverse side effects/serious reactions:	
Length of time this treatment is recommended:	

Other Information: _____

_____

Date: _____Physician's Signature: _____

*** ANY** medication that is to be administered at school must be brought to school by a parent or guardian, NOT the child. Special situations should be discussed with the principal.

** State law requires notification of the physician of **ANY REQUEST** to withhold, discontinue or change the dose or schedule of a medication. Changes **REQUIRE** that a new authorization form be completed. Any discontinued medications not picked up within two weeks will be destroyed.

Adopted: April 13, 2000
Revised: May 19, 2016