

**Solvay Union Free School District**  
**Student Health Services**

**Solvay Elementary School**  
Grades K – 3  
Fax: 484-1412

**Solvay Middle School**  
Grades 4 – 8  
Fax: 484-1444

**Solvay High School**  
Grades 9 - 12  
Fax: 484-1404

**NOTE:** Please fax this form to the School Nurse at the school in which your child attends.

**AUTHORIZATION FOR MEDICATION**  
**TO BE TAKEN DURING SCHOOL HOURS**

*This form is required for both prescription and over-the-counter medications.*

**This order EXPIRES at the end of the current school year.**

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**PARENT PERMISSION (required):**

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

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate her/himself as also authorized by me and the prescribing physician Dr. \_\_\_\_\_.

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Date Parent/Guardian Signature Home Phone # Emergency #

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**PHYSICIAN'S ORDER (required):**

Diagnosis for which medication is given: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Form: \_\_\_\_\_ Dose: \_\_\_\_\_ If daily, at what time? \_\_\_\_\_

If as needed, describe indications: \_\_\_\_\_

How soon can it be repeated? \_\_\_\_\_

Is child authorized to medicate her/himself?  Yes  No

Please list significant side effects: \_\_\_\_\_

Length of time treatment is recommended: \_\_\_\_\_

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

\_\_\_\_\_  
M.D. \_\_\_\_\_  
**Physician's Signature** **Date**

\_\_\_\_\_  
**Print Name** **Physician's Phone**

\_\_\_\_\_  
**Physician's Address**