Print Form

Solvay Union Free School District

Student Health Services

Solvay Elementary School	**Solvay Middle School**	**Solvay High School**
Grades K – 3	***Grades 4 – 8***	***Grades 9 - 12***
Fax: 484-1412	**Fax: 484-1444**	**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.

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 #

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

Rev. 11/06/07