PRESCRIPTION MEDICATION AUTHORIZATION FORM

(To be completed by the parent. Please send medication in a prescription labeled bottle).

(Student's Name) _____ (DOB) _____ (Grade/Teacher) _____

(Name of Medication) _____ (Dose) _____ (Time) _____

(Diagnosis - Special Instructions) _____

I authorize the employees of the Windsor C-1 School District to dispense this medicine to my child and to contact my physician below to discuss any questions or concerns about this medicine.

NOTE: Any medicine that is routinely given just before or during lunchtime WILL NOT be given on early dismissal days unless prior arrangements are made with the school nurse.

Signature Parent/Guardian _____ Date _____ Home Phone (____)_____ Work Phone (____)_____

Physician's Name _____ Phone _____ Cell Phone (____)_____

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PRESCRIPTION MEDICATION AUTHORIZATION FORM

(To be completed by the parent. Please send medication in a prescription labeled bottle).

(Student's Name) _____ (DOB) _____ (Grade/Teacher) _____

(Name of Medication) _____ (Dose) _____ (Time) _____

(Diagnosis - Special Instructions) _____

I authorize the employees of the Windsor C-1 School District to dispense this medicine to my child and to contact my physician below to discuss any questions or concerns about this medicine.

NOTE: Any medicine that is routinely given just before or during lunchtime WILL NOT be given on early dismissal days unless prior arrangements are made with the school nurse.

Signature Parent/Guardian _____ Date _____ Home Phone (____)_____ Work Phone (____)_____

Physician's Name _____ Phone _____ Cell Phone (____)_____

Rev. 05/10F

Windsor C-1 School District
Imperial, MO

OVER-THE-COUNTER MEDICATION AUTHORIZATION FORM

To be completed by the physician and the parent.

According to the Nurse Practice Act for the State of Missouri, nurses are not allowed to dispense medication unless prescribed by a physician. Please use this form when sending over-the-counter medication to school.

Student _____ D.O.B. ___/___/___ GR/Teacher _____

PHYSICIAN'S SECTION (To be completed by the physician).

Medication _____ Dose _____ Interval _____

Diagnosis/Reason for Treatment

_____

Special Instructions/Restrictions

_____

Medication _____ Dose _____ Interval _____

Diagnosis/Reason for Treatment

_____

Special Instructions/Restrictions

_____

Medication _____ Dose _____ Interval _____

Diagnosis/Reason for Treatment

_____

Special Instructions/Restrictions

_____

_____ _____

Physician's Printed Name Date

_____ (____)_____

Physician's Signature Office Phone

PARENT SECTION (To be completed by the parent).

I authorize the employees of the Windsor C-1 School District to dispense the above over-the-counter medicine(s) to my child, and to contact my physician to discuss any related questions or concerns.

NOTE: Any medicine that is routinely given just before or during lunch WILL NOT be given on early dismissal days unless prior arrangements are made with the school nurse.

_____ _____ _____ _____

Parent Signature Date Home Phone Work/Cell Phone

Rev. 04/10F