

Emerson Waldorf School
MEDICATION AUTHORIZATION
2009-10

PHYSICIAN: COMPLETE ALL ITEMS IN BOLD

Student's Name: _____ **Date of Birth:** ___/___/___

Medication: _____ **Dosage:** _____ **Route:** _____ **Frequency:** _____

(No injection will be given except in extreme emergency, such as allergy to wasp or bee sting)

Time(s) medication is to be given: _____ **Dates to be given from:** ___/___/___ to ___/___/___

(Medication request will be in effect until the beginning of the next school year unless otherwise specified)

Condition: _____

Type of medication: (circle) Tablet Capsule Liquid Inhalation Ointment Injection Other _____

Significant Information (side effects, adverse & omission reactions): _____

Contraindications for Administration: _____

This medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed and the time to be given.

Physician's Signature: _____ **Telephone:** _____ **Date:** ___/___/___

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release EWS and their agents and employees from all liability that may result from my child taking the prescribed medication.

Parent/Guardian Signature: _____ **Telephone:** _____ **Date:** ___/___/___