Harrison Community Schools
P.O. Box 529, 224 W. Main Street, Harrison, MI 48625
(989) 539-0411 or FAX (989) 539-7491

PHYSICIAN'S AUTHORIZATION FOR MEDICATION AT SCHOOL

This applies to ALL Medication - Prescription and Non Prescription Drugs

The Harrison Community Schools do not have medical personnel present on a regular basis to administer medication/treatment. If appropriate, please order medication/treatment to be administered at home.

Name of Child: _____ Birthdate: _____

School: _____ Grade: _____

Physician's Orders
(To be completed by physician)

Medications must be in original container

Name of Medication _____ Order Expires: _____

Dosage (Mg., cc., puffs) _____

How Often? _____ If prn, allowable frequency _____

Form of Medication: pill/capsule liquid inhaler nebulizer injection topical

Time to be given at school _____ Time to be given at home _____

Unusual side effects or comments _____

The parent has agreed to supply this medication to the school as needed. Should the student manifest any of the above symptoms which may be caused by the medication, I understand that the parent will be contacted.

_____ _____
Physician's Name Physician's Signature

_____ _____
Phone Date

PARENT/GUARDIAN PERMISSION

I hereby request that my child (named above) receive medication during school hours. I authorize school personnel to consult with the above physician regarding my child's health condition/medication.

_____ _____ _____
Parent/Guardian Signature Phone Date

Initiated 5/1999 Revised 5/2005