PHYSICIAN'S PRESCRIBED MEDICATION FORM

This form **MUST** be completed and signed by both the physician and the parent/guardian before the prescribed medication will be administered by Birchwood School designee.

PART A. To be completed by physician:

1. Student name ____Grade____________
2. Student address____
3. Diagnosis____
4. Prescribed medication_________________________________ Dosage___________________
5. Times or intervals of administration____
6. Date administration is to begin_________________________________ Date to End _________
7. Adverse reactions to be reported ____
8. Special instructions for administration or storage of medication _________________________
   ____
9. Physician's name____
   Physician's telephone number____
   Physician's signature ____ Date___________

PART B. To be completed by parent/guardian:

Name of student____

Name of medication____

Name of parent____

I hereby authorize designated school personnel to administer the above medication as instructed by the physician in PART A of this form.

I agree to deliver the medication to the school in the container in which it was dispensed by the prescribing physician or pharmacist.

I agree to notify the school in writing if the medication, dosage or other information provided by the physician is changed or eliminated.

Parent/Guardian signature____ Date __________