Birchwood School of Hawken

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 of Hawken 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 _____