Graham Local School District

<u>Prescription Medication Authorization Form</u>

All blanks must be completed

1. ____

   Pupil's name, complete address, and phone number

2. ____

   Building and grade level of pupil

3. ____

   Name of prescription medication and dosage to be administered

4. ____

   List the time of day prescription medication is to be administered

5. ____

   List the date the administration of the prescription medication is to begin

6. ____

   List the date the administration of the prescription medication is to cease

7. ____

   List any severe, adverse reactions that should be reported to the physician

8. ____

   The name of the prescribing physician and one or more telephone numbers at which physician can be reached in case of an emergency

9. ____

   ____

   List all special instructions for the administration of the prescription medication including sterile conditions and storage

____________________   ____________________

Date   Signature of Physician

* *

I, ______________________ (Name of Parent/Guardian), request that authorized personnel of Graham ____________ (Building)

administer the above medication to my son/daughter, ______________________ (Name of Pupil), according

to the written instructions. I further agree to relieve the Graham Local Board of Education and its employees of

liability for administration of the non-prescription listed on this form.

____________________   ____________________

Date   Signature of Parent/Guardian

Graham Local School District
Medication Record

School Year _____ School _____ Grade _____ Teacher _____

Student's Name _____ Birthdate _____ Age _____ Weight _____
Parent's Name _____ Phone _____ Work Phone _____

Physician's Name _____ Phone _____ Fax _____

Medication _____ Dose _____ Time _____
Comments/Instructions _____
_____

	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
Apr																															
May																															
Jun																															

Codes: (--) Weekend (F) Field Trip (H) Holiday (E) Early dismissal (A)Absent (W) Dose Withheld (*) Time change/comment
*** Enter time given and givers initials in box

Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____

Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____