Seabrook Middle School

(603) 474-9221
Fax – (603) 474-8020

MEDICATION AUTHORIZATION

The following section is to be completed by PARENT/GUARDIAN:

Child's name_______________________________________ DOB: _____________________________

________________________________ ______________________________ _____________
Physician's Name Address Phone

I request that my child be assisted by authorized persons at school, in taking the following medication(s) described below. The school nurse has my permission to consult the physician named above regarding this medication and treatment if needed.

________ ___________________________________ _________________ ________________
Date Parent/Guardian Signature Home Phone Emergency Phone

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: ____

NAME MEDICINE: ____

FORM/ DOSE: ____

IF MEDICINE IS TO BE GIVEN DAILY, AT WHAT TIME? __________________________

IF MEDICINE GIVEN WHEN NEEDED, DESCRIBE
INDICATIONS: ____

HOW SOON CAN IT BE REPEATED? ____

LIST SIGNIFICANT SIDE
EFFECTS: ____

LENGTH OF TIME TREATMENT IS RECOMMENDED: ____________________________

Does the severity of this medical condition necessitate that the student be permitted to carry this medication and self-administered as needed? Yes or No (please circle)

Does the student demonstrate the level of understanding and responsibility required for safe self-administration at school? Yes or No (please circle)

____________________ ____
Date Physician's Signature