AUTHORIZATION TO DISPENSE, MONITOR AND TRANSPORT PRESCRIPTION MEDICATIONS and MONITOR MEDICAL DIAGNOSES

I.	This section to be completed by the child's <u>ATTENDING PHYSICIAN</u> :					
My patient.		, is prescribe	, is prescribed the following medication(s) and dosages:			
	Printed Name se also indicate the frequency for					
	Name of Medication	Dosage	When Taken	Frequency	How long has student taken this medication	
+						
	rinted Name of Attending Physician This section to be completed by receive the medication(s) listed a will be kept confidential and wil	Signature of Atter y PARENT/GUARDIA above while at school, at 1 be given to others at S	AN: according to the standar MA only when needed	Telephone Nu	has my permission to	
	be delivered to the Infirmary in t	heir ORIGINAL contai	ners.			
Printed Name of Parent/Guardian		Signature of Parent/0	Signature of Parent/Guardian		Relationship to Student Date	
	PARENTA ne parent or guardian of er medications for: Vacat		, I give permi	ssion for this stu	dent to personally transpor	
		ions/Hondays	Long Leave We		Travening on Campus	
arer	nt/Guardian Signature		Date			