BATH LOCAL SCHOOLS
MEDICATION/MEDICAL PROCEDURE AUTHORIZATION FORM

Medication must be sent to school in original container as dispensed by physician or pharmacist.

Name of student____Date of request________________

Address____Teacher/homeroom_____________

____Grade_______________________

Any known allergies____

Name of medication____

Dosage (or procedure required)____

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(procedure must be on child's I.E.P., if appropriate)

Times/Intervals medication is required____

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Possible reactions which should be reported to the physician____

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Special instructions, including storage and sterile requirements____

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Date medication/procedure to begin____

Date medication/procedure no longer needed____

*************** **REQUIRED BY STATE LAW** ***************

Physician's signature____

Date______________________________ Telephone____

Parent/Guardian Authorization

I, ____________________________ authorize the school personnel to administer the medication or procedure as instructed by the physician, and agree: (1) to deliver the medication to the school; (2) to notify the school if there is a change in physicians; (3) to notify the school if the medication, the dosage, or the procedure is changed or to be eliminated.

(Name of parent/guardian)

____ ________________________

(Signature of parent/guardian) (Date)

Phone number (during school hours)____________________________