LESLIE PUBLIC SCHOOLS

PHYSICIAN'S AUTHORIZATION TO ADMINISTER MEDICATION TO STUDENT AT SCHOOL

Woodworth Elementary (WW) *Grades K-4*
Leslie Middle School (LMS) *Grades 5-8*
Leslie High School (LHS) *Grades 9-12*

- ✓ This form applies to all prescription and non-prescription medications
- ✓ Any medication sent to school must be in the original container
- ✓ All medication must be left in the school office
- ✓ NOTE: Leslie Public Schools does not have medical personnel on staff at any of the school buildings on a regular basis. Your child's medication or treatment should be administered at home whenever possible.

NAME OF CHILD: ____________________________ BIRTHDATE: ______________________ GRADE: ___________

TO BE COMPLETED BY PHYSICIAN/LICENSED PRACTITIONER:

Medication Name	Form of Medication	Dosage (amount)	Frequency (how often)	Time to be given	Side Effects
	❑ pill/capsule ❑ inhaler ❑ nebulizer ❑ topical ❑ injection ❑ liquid ❑ Other (list):				
Order for medication expires on:					

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Order for medication expires on:					

PHYSICIAN'S AUTHORIZATION

The medication listed above needs to be administered during school hours.

Physician's printed name: ______________________________ Phone Number: ________________________

Physician's Signature: __________________________________ Date: _________________

PARENT AUTHORIZATION

I request that my child receive the medication listed above during school hours. I understand that the medication must be sent to school in the original container and that all medication must be left in the school office to be administered by dosage, frequency, and time as directed by the physician above.

Parent Signature: ___________________________________ Date: ___________________________