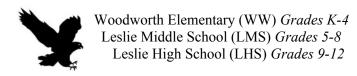
LESLIE PUBLIC SCHOOLS

PHYSICIAN'S AUTHORIZATION TO ADMINISTER MEDICATION TO STUDENT AT SCHOOL



- ✓ 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:	BIRTH	HDATE:		GRADE:		
то ве	COMPLETED BY PHYSIC	CIAN/LICE	NSED PRAC	TITIONER:		
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:						
Medication Name	Form of Medication pill/capsule inhaler	Dosage (amount)	Frequency (how often)	Time to be given	Side Effects	
	nebulizer topical injection liquid Other (list):					
Order for medication expires on:						
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:	_ = 0.000 (400).					
	PHYSICIAN'S A	UTHORIZ	ATION			
The medication listed above needs	to be administered during scho	ool hours.				
Physician's printed name:			Phone Number:			
Physician's Signature:		Date:				
	PARENT AUT	THODIZAT	ION			
I request that my child receive the school in the original container and and time as directed by the physici	medication listed above during I that all medication must be le	school hou	rs. I understar			
Parent Signature:		Date:				