Delaware Comm.
School Corp.

PHYSICIAN'S
AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

Re: _____ DOB _____

This student has _____ for which the following medications have been prescribed for treating and preventing emergencies. This student has been trained in the use of these medications.

Medication	Dose	Route	Time

Please notify the parents, if these do not relieve the students' problems.

Daytime phone number_____

Evening phone _____

If you have any questions or concerns, please phone me at the above-listed numbers.

_____ This student possesses enough skill and maturity to carry the medication and to use it under the general supervision of school personnel.

_____ This student's medication must be kept by school personnel and administered only with detailed and specific supervision.

Adverse effect that should be looked for: _____
Potential for abuse or addiction: _____
Comments:_____
_____
_____

Physician's Name (please print) _____
Physicians' Signature: _____

Parent's Signature:_____
Date:_____