

**AUTHORIZATION FOR POLAND SCHOOL PERSONNEL
TO ADMINISTER MEDICATION**

To be completed by physician:

Student's Name: _____

Student's Date of Birth: _____

Home Telephone Number: _____

Medication Name & Dosage: _____

Time & Route of Administration: _____

Reason for Medication: _____

Side Effects: _____

Start / Stop Date: _____

Physician's Name: _____

Physician's Telephone: _____

I understand school employees are not medically trained and that the school nurse may not always be available to give medication. However, in my professional opinion, the above named student needs the particular medication during school hours to maintain his/her physical, emotional, or academic wellbeing.

In the event of side effects to the medication, school officials should take the following action:

Physician Signature: _____ Date: _____

To be completed by Parent / Legal Guardian

I understand school employees are not medically trained personnel and that the school nurse may not always be available to dispense medication. With full knowledge of this, I hereby give permission for the administration of the medication specified above by the school nurse or by other non-medical school personnel designated by the school principal.

Parent Signature: _____ Date: _____

Attach "Side Effects" Data Sheet