MILL SPRINGS ACADEMY

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Authorization for Prescription Medication

Date_______________________________________

Student's Name____

I request that Mill Springs Academy, through its nurse or designee, administer medication to my child according to the physician's instructions. I understand that the school nurse will send the appropriate dose(s) of my child's medication on field trips to be given by my child's teacher.

_______________________________ _______________________________
Parent/Legal Guardian's Signature Phone Number

Physician's Statement

Name and strength of medication ____

Dosage to be given ________________________Time to be given____________________________

Expected duration of administration____

Possible side effects:

- ☐ Headaches ☐ Restlessness ☐ Tics
- ☐ Stomachaches ☐ Decreased Appetite ☐ Sedation
- ☐ Other____

Name and strength of medication ____

Dosage to be given ________________________Time to be given____________________________

Expected duration of administration____

Possible side effects:

- ☐ Headaches ☐ Restlessness ☐ Tics
- ☐ Stomachaches ☐ Decreased Appetite ☐ Sedation
- ☐ Other____

____
Physician's Signature

____
Physician's Printed Name

____
Phone Number (may attach a business card)

The school nurse, Ann Hartin, should be notified of all medication changes.