MEDICATION AUTHORIZATION/RECORD OF DISPENSATION

Child's Name	Date	
Child's Teacher		
AUTHORIZATION		
I authorize the staff of the Friends School of A child, with instructions for dispensation as rec		tion(s) to my
Medication and prescription number		
Medication must be administered from the or on it.	riginal container and must have the child's	name written
Time medication is to be given		
Clock hour, for instance 12:00pm, not lunch	time.	
Amount of medication to be given		
Possible side effects		
Specify calendar days medication to be given		
(For instance, March 1–12, not 12 days.)		
Child's known allergies		
Condition medicine is to treat		-
Condition is brought on by		
Symptoms to watch for		
		-
 Does child usually get a before-school dose? _	YesNo	
If so, at what time?		
How much time is needed between doses?		

What is th	e maximum amo	ount to be given in a 2	4-hour period?	
Any other i	important notes a	about the medicine?		
Physician's	name and phon	e number		
Parent/Gua	ardian's signature	2		
Work pho	ne ()		Home phone	
				(over)
	y FSA Staff Onl			C
Date	TIME	AMOUNT	Adverse Reactions	STAFF SIGNATURE