Dover Middle School Health Services
Phone:516-7287 Fax:516-8462
AUTHORIZATION FOR MEDICATION

Office Use Only:
□ Medication supplied
Date rec'd_____
By _____

Student's Name _____

Date of Birth_____ Grade_____

Allergies to Medications:_____

I request that my child be assisted in taking medication(s) described below at school and on field trips by authorized persons. I agree that all ***medications will be brought to school in original containers with prescriptive labels***.
Please note: **For prescription medications the school may only accept a 30-day supply**.

Date_____ Parent Signature_____

TO BE COMPLETED BY PARENT: OVER THE COUNTER MEDICATION

(Not supplied by school, family must supply)

Reason for Medication:_____
Name of Medication:_____
Dose (amount):_____
How soon can it be repeated?_____
Please Check: ___School Year OR Limited to _____days

To BE COMPLETED BY PARENT: PRESCRIPTION MEDICATION

Name of Medication_____
I request prescription medication to be given according to physician's order.

TO BE COMPLETED BY PROVIDER: PRESCRIPTION MEDICATION

Diagnosis for which medication is prescribed: _____
Name of Medication:_____
Dose:_____
Time:_____
Indications if PRN:_____
Frequency:_____
Significant side effects:_____
Other information:_____
Please check: ____School Year (or) _____Limited to _____days

_____ _____ _____ _____
Provider's Printed Name Provider's Signature Date Phone Number