

To be Completed by the Physician/Healthcare Provider

Medication Name & Purpose:

Prescribed Dosage:

Administration Instructions/Other Special Instructions:

Side Effects:

Physician's Signature

Date

Physician's Name (*please print legibly*): _____

Office/Contact Number: _____

To Be Completed by Parent/Guardian

Emergency Contact Names & Numbers:

*Other Approved Medication - shall be defined as prescribed medication used for emergency purposes and/or medication approved by Student Health Services in collaboration with the student's health care provider.

Fulton County School System reserves the right to seek emergency medical treatment for the student when deemed necessary and appropriate.

This form is effective only for the school year in which such authorization is granted; subsequent authorization may be granted in any school year in accordance with this policy.

Clinic Assistant/Cluster/Special Needs Nurse Signature

Date

Revised 06/08