MAGGIE L. WALKER GOVERNOR'S SCHOOL

School Health Services

AUTHORIZATION FOR MEDICATION

I certify that in my opinion it is medically necessary that the medication prescribed below be administered to _____ during school hours and that this medication may be administered by school personnel.

Prescription Medication:

Dosage and Time:

Duration:

_____ M.D. _____

Print Name Signature

_____ _____

Phone Date

I, _____ the parent or guardian of _____, request that the Clinic Attendant or the principal's designee at MLWGS administer the medication(s) prescribed above to my child during school hours. I understand that the person who will administer the medication may be inexperienced, and I agree that I shall not hold such person or the Regional Board liable in any way for any harm or injury resulting from the administration of such medication. I also agree to furnish said medication in the bottle supplied by the pharmacy with label intact.

_____

Signature of Parent or Guardian

_____

Date

Home Telephone _____ Cell Telephone _____