revised 3/2010

SUZUME NO GAKKO

AUTHORIZATION TO TAKE MEDICATION IN SCHOOL

TO BE COMPLETED BY PARENT OR GUARDIAN:

Child's Name _____ Grade_____

I request that my child be allowed to take medication at school on _____(dates) at _____a.m., _____p.m. according to instructions from his/her physician. I understand that it is my responsibility to send the medication to school in the ***ORIGINAL*** pharmacy container labeled with the drug name, date, child's name, prescribing physician's name, dosage and directions.

_____ _____
PARENT SIGNATURE *DATE*

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IN THE EVENT THAT THE CHILD'S PHYSICIAN ORDERS NON-PRESCRIPTION MEDICATION, THE FOLLOWING RELEASE IS REQUIRED:

TO BE COMPLETED BY PHYSICIAN:

Diagnosis: _____

Medication and Instructions: _____
_____

Medication requested for _____ to _____(Length of time)

Comments: _____
_____
_____

_____ _____ _____
PHYSICIAN'S SIGNATURE *PHONE NO.* *DATE*

……

MEDICATION ADMINISTERED AT SCHOOL

Date	Time Given	Given By	Date	Time Given	Given By