

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

.....
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