

**Plano Community Unit School District #88**  
**Physician Prescribed Medication Authorization Form – 2010-11**

***To be completed by parent/guardian:***

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Emergency Phone No. \_\_\_\_\_

I hereby grant permission for the above named school to issue medication as described below for the named child.

\_\_\_\_\_  
Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

***To be completed by student's physician:***

Name of Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Time(s) to be given in school \_\_\_\_\_

Diagnosis requiring medication \_\_\_\_\_

Intended effect of this medication \_\_\_\_\_

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition?

\_\_\_\_\_  
Possible side effects, if any \_\_\_\_\_

Physician Name & Address \_\_\_\_\_

Office Address & Phone \_\_\_\_\_

\_\_\_\_\_  
Physician Signature Required \_\_\_\_\_ Date \_\_\_\_\_

*Note: This form shall be effective for one school year.*