

Plano Community Unit School District #88
Physician Prescribed Medication Authorization Form – 2009-10

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.