AMERICAN HERITAGE SCHOOL

AUTHORIZATION FOR MEDICATION
FAX: (954) 472-0573

Name of Student: _____ Date of Birth: _____

Grade/Teacher: _____ Date: _____

MEDICATION TREATMENT PLAN
TO BE COMPLETED BY PHYSICIAN

Diagnosis: _____

_____

Medication, Dosage, Time & Direction for Administration: _____

_____

_____

Note: Medication must be supplied in the original prescription container. Ask pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.

Side Effects/Special Instructions: _____

_____

_____

Note to physician: Please complete the plan on the back of this form for students who require special health procedures during school hours.

_____ _____
Printed Name or Stamp of Physician Physician's Signature

_____ _____
Physician's Telephone Number Physician's FAX Number

PARENTAL PERMISSION
TO BE COMPLETED BY PARENT/GUARDIAN

I grant the principal or his/her designee the permission to assist in the administration of each prescribed medication/procedure to be provided during the school day (cooporative/extended care inclusive) including when _____ is away from school property on official school business.
Name of Student

_____
Signature of Parent/Guardian Date Daytime Phone

TREATMENT PLAN FOR STUDENTS NEEDING HEALTH PROCEDURES DURING SCHOOL HOURS

Treatment Plan: _____

Special Procedures (List special procedures in which students have been trained, i.e. insulin administration, use of Epi-pen, nebulizer, monitoring blood glucose, etc.) _____

Please list any limitations that should be considered, i.e.physical education, outdoor activities, etc.

Please state the **EMERGENCY PRECAUTIONS** that should be considered, i.e. allergy triggers, diabetic reactions, etc.:

_____

Physician's Signature Phone Number Date