

Heldeberg Workshop

Parent and Physician's Authorization for Administration of Medication

All medications, prescription as well as over the counter medications must have physician orders for medication to be present/given at the Workshop.

To be completed by parent or guardian:

I request that my child _____ Age _____ receive the medication prescribed below by my child's physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy.

Home Telephone: _____ Work phone _____

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

To be completed by physician:

I request that my patient as listed below, receive the following medication(s):

Name of Student _____ DOB _____

Reason for medication _____

MEDICATION	DOSAGE/ROUTE	FREQUENCY/TIME

Duration of Treatment: _____

Possible Side Effects or Adverse Reactions (if any): _____

Please check box if self-directed:

This child is considered to be self-directed and may carry and self-administer this medication.

Physicians Printed Name or Stamp: _____

Physician's signature: _____ Date: _____

Address: _____ Phone: _____

Medication must be in the original pharmacy labeled container with specific orders and name of medication. We cannot accept school orders that expire in June.