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):_____

Physician: Please check box below and initial on right for self-directed permission: _____
❒ 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.