Limestone DISTRICT SCHOOL BOARD

Form 314-A1- Physician's Authorization and Request for the Administration of Prescribed Medication

Student Name: _____ School: _____ Grade: _____

Date of Birth: _____ Teacher: _____ Classroom: _____
YYYY/MM/DD

Physician's Statement

Drug (Generic/trade name)				
Formulation (Description)				
Dose (e.g. Volume, mg)				
Administration (e.g. Oral, inhaled)				
Dosing Interval				
Indication				
Length of Treatment				
Previous Use? (Y/N)				
Anticipated Untoward Reaction (Y/N) Reaction Action				
Special Instructions: Requirements, warnings, storage, availability, etc.)				

Physician's Signature: _____ Address: _____ Date: _____

Physician's Name: _____ Phone: _____

Note: This form is completed annually and is valid until the prescription expires or is altered by the physician, whichever comes first. It is the responsibility of the parent/guardian/student to ensure that a new form is completed when required and returned to the school. Any cost associated with the completion of this medical request is the sole responsibility of the parent/guardian.

Personal information on this form is collected under the authority of Board policy and will be used by school staff for the purpose of distributing medication as directed above. Questions about this collection may be directed to the Board at 613.544.6920.