

BARRINGTON SCHOOL DEPARTMENT
BARRINGTON, RI 02806

MEDICATION AUTHORIZATION

Student Name _____ Date of Birth _____

School _____ Grade _____

Medication will be supplied by me in the original prescription labeled container with my child's name, name of medication, dosage and time to be given. I understand that if it is necessary for my child to take medication on a field trip away from school, I will provide one school day's supply of the medication in the original prescription bottle for my child to self-carry and self-administer.

Parent/Guardian Signature _____ Date _____ Home Phone Number _____

To be completed by your child's physician

_____ is under my care. Please give the medication prescribed by me as follows:

Name of Medication _____

Dosage in School _____

Approximate Time of Administration _____

Diagnosis _____

Side Effects _____

Other Instructions _____

Signature of Physician _____ Date _____ Phone number _____