



Administration of Medication

_____ School

_____ Child's last name

_____ Child's first name

_____ Sex

_____ Date of Birth

_____ Physician's name

1524 Leander Rd, Georgetown, TX 78628
_____ Physician's address

512-863-7586
_____ Phone

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below).

_____ Date _____ Signature Parent / Guardian () _____ Home phone () _____ Emergency Phone

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication if given: _____

Name of medicine:

Form:

Dose:

If medicine to be given DAILY, at what time?

If medicine to be given "WHEN NEEDED", describe indications:

How soon can it be repeated?

Is child authorized to medicate herself / himself?

List significant side effects:

Length of time this treatment is recommended:

Other information: _____

Date: _____ **Physician's signature:** _____

Recommendations developed by The American College of Allergists
800 E NW Hwy, Ste 1080, Palatine, IL 60067

Endorsed by:

The Asthma & Allergy Foundation of American
The American Academy of Allergy & Immunology
The American Academy of Pediatrics