Doris E. Hossalla, M.D.
3613 Williams Drive, Ste 801
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www.georgetownkids.com

Office Hours:
Monday - Thursday 9:00am - 7:00pm

Appointments:
Monday - Thursday 1:00pm - 7:00pm

Authorization to Administer Medication

_____
School

_____ _____ _____ _____
Child's last name: Child's First name: Sex: Date of birth:

Doris Hossalla, M.D. 3613 Williams Dr, Ste 802, Georgetown, TX 78628 (512)930-0191
Physician's name Physician's address Physician's 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 Home phone Emergency phone

Name of medicine:
Form:
Dose:
If given daily, at what time?
If 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:

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication if given: _____

Other Information: _____

_____

_____

Date:_____ Physician's signature: _____