To the Physician:

The Pinconning School District requires that all of the following information be provided before it will administer medication or treatment to the student.

_____	_____	_____
Name of Student	**Address**	**Grade**

I have prescribed the following medication: _____

Beginning Date _____ **Ending Date** _____

Dosage, instructions, or precautions:

_____

_____

_____

Report the following side effects to my office immediately:

_____

_____

_____

Physician's Signature _____ **Telephone** _____

Printed/Typed Name _____ **Date** _____

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication/treatment:

_____ _____

_____ _____

_____

Principal