Arbor Park
School District 145

17301 Central Avenue
Oak Forest, IL 60452
PHONE: 708-687-8040
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Medication authorization form for Parents and Physicians

I hereby authorize the administration of medication under doctor's orders to my child during school hours.

Child's name_____

Address, city/ Zip_____

Phone number_____

Date_____Parents signature_____

Name of Medication in Prescribed bottle_____

TO BE FILLED OUT BY PHYSICIAN:

Physician's name_____

Address/city/Zip_____

Phone number_____

Medication Prescribed_____

Reason for prescription_____

Dosage_____Interval_____

Date_____Physicians signature_____

Physicians comments/instructions:

Note: Medication must be kept in original container (from pharmacy) clearly marked with students name, Rx number, type of medication and dosage. No over the counter medication will be administered without physicians instructions. Parents section must be filled out completely.

Thank you!