NORTHERN RUSH COUNTY SCHOOLS

MAYS COMMUNITY ACADEMY

AUTHORIZATION TO DISPENCSE RESCRIBED MEDICATION DURING SCHOOL HOURS

COMPLETED BY PHYSICIAN

The personnel at Mays Community Academy (MCA) are hereby notified that _____, a student at MCA, is under my care and that said school personnel are hereby requested to give the said student medication as listed below, in accordance with the directions listed below. The undersigned physician further acknowledges that the legal custodian of said student has been informed as to the need for said medication and the directions for its use.

Diagnosis for which medication is given: _____

Name of medication: _____

Dosage: _____ Form: _____ Time to be given: _____

If medication is to be given "when needed," describe indications:

_____

How soon can it be repeated? _____

Is child authorized to carry "when needed" medications on his/her person? Yes __ No __

List significant side effects: _____

Length of time this medication is recommended: _____

Other information: _____

Signature of Physician _____

Date _____ Phone number _____