JAMES BAY LOWLANDS SECONDARY SCHOOL BOARD

CONFIDENTIAL

PHYSICIAN'S AUTHORIZATION FOR THE USE OF PRESCRIBED MEDICATION

STUDENT'S NAME: ____

ADDRESS: ____

____

SCHOOL: ____

This is to advise that I have prescribed the medication listed below for the purpose of:

____

____

____

A) Name of medication: ____

____

B) Dosage: ____

____

C) Time of Administration: ____

D) Additional Instructions: ____

____

____

E) Are there any side effects about which we should be aware?

____

____

____

F) Please check one of the following: ______ medication necessary on an on-going basis

______ medication necessary on a short-term basis

PHYSICIAN'S NAME: ____

ADDRESS: ____

____

PHONE: ____

I certify that the prescribed medication is needed during the school day.

____ ____________________

SIGNATURE OF PHYSICIAN DATE

Note: This authorization form will remain valid until there is a change in the prescription, but in no case, for longer than one period of residence.

DISTRIBUTION: Original – NLSS Office **Copies: Weeneebayko Area Health Authority** and **Parent/Guardian**