rm must be completed fully in order -5(mus)u0A30 G[-outha)-3(c82(amp)3( )-4(o)4pde)8(r)-4atorso tfft be78(r)-4is t dter the reedmsehication or -5(mus)u0A3(t)

HILD'S NAME (First Middle Last)

2. DATE OF BIRTH (mm/dd/yyyy)
____/____/______

EDICATION SHALL BE ADMINISTERED

3a. FROM (mm/dd/yyyy) 3b. TO (mm/dd/yyyy)

the year in which this form is dated in 7b below unless more restrictive dates are specified in 3a and 3b. This authorization is NOT TO EXCEED 1 YEAR.

Yes No Yes No Not emergency med

Emergency Medication: Yes No Known side effects:

Yes No Yes No Not emergency med

Emergency Medication: Yes No Known side effects:

Yes No Yes No Not emergency med

Emergency Medication: Yes No Known side effects:

RESCRIBER'S NAME/TITLE

This space may be used for the Prescriber's Address Stamp

PHONE FAX

RESS

STATE ZIP CODE

RESCRIBER'S SIGNATURE (Parent/guardian cannot sign here)
al signature or signature stamp only)

5b. DATE (mm/dd/yyyy)

ARENT/GUARDIAN SIGNATURE

6b. DATE (mm/dd/yyyy)

6c. INDIVIDUALS AUTHORIZED TO PICK UP MEDICATION

HOME PHONE #

6e. CELL PHONE #

6f. WORK PHONE #

RESCRIBER'S SIGNATURE
F-ADMINISTRATION/SELF-CARRY

7b. DATE

8a. PARENT/GUARDIAN'S SIGNATURE
FOR SELF-ADMINISTRATION/SELF-CARRY

8b. DATE