Jamesville-DeWitt Central School District

Medication Authorization Form

Student Name:____

Date of Birth:__________________ **Grade:**_____ **School:**__________________________

Diagnosis:____

Medication Name:____

Dosage

Amount/Frequency:________________________

Route:__________________________________

Time:___________________________________

Possible Side Effects/Adverse Reactions:____

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- -

Physician Signature:_________________________________ **Date:**_________________

Physician Name (Print):____

Physician Address:____

Physician Phone Number:____

- -

Parent/Guardian Signature:____

Date Signed:____

School nurse contact information is available at www.jamesvilledewitt.org.