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.

Jamesville-DeWitt Central School District * P.O. Box 606 * DeWitt, NY 13214