Cornerstone Community School

90 W. Overdale Drive
Tallmadge, OH 44278

T: (330) 686-8900
F: (330) 686-8224

PRESCRIPTION MEDICATION AUTHORIZATION FORM

Student_____ Grade_____

Address _____Date of Birth _____

TO BE COMPLETED BY PHYSICIAN:

Name of medication _____Dose_____

Time to be given (during school hours) _____

Reason for medication _____

Form of medication:

___tablet/capsule ____liquid _____inhaler ____nebulizer ____other

Start date: _____ Stop date: _____

Severe reactions to be reported to the physician:

_____

Special instructions: _____

Date: _____Physician's Signature: _____

Physician's Name _____ Phone _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child to receive medication at school according to the Cornerstone Community School's policy and as instructed by the physician and agree to:

- ► Assume responsibility for safe delivery of the medication to the school.
- ►Have a new form completed by the physician if medication or dosage is changed.
- ►Notify the school of physician changes.

Parent/Guardian Signature _____ Date _____

Daytime phone number _____

This form will expire at the end of the school year

Revised 7/15