

AUTHORIZATION FOR DISPENSING MEDICATION

Over the Counter Medications must match label directions
If child's age indicates "consult physician", doctor must write or fax prescription.

Child's Name and Date of Birth

Date to be administered

Name of Medication Prescription #

Send medicine home daily

Keep medicine at school
Until finished

Amount to be given

Time to give

Doctor's Name

Parent Signature Date

CCMS Use Only:

Rx label matches parents instruction _____ Medicine is in File

over the counter label matches parent inst. _____ Medicine is in Fridge

over the counter label does not match, Dr. permission attached

Date	Time	Medication	Amount	Initials	Why not at given time

** Continued on back

Returned to child's parent/guardian

Thrown away

Date returned or thrown away