BARRINGTON SCHOOL DEPARTMENT
BARRINGTON, RI 02806

MEDICATION AUTHORIZATION

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Student Name   Date of Birth

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School   Grade   Teacher/Cluster

Medication will be supplied by me in the original prescription labeled container with my child's name, name of medication, dosage and time to be given. I understand that if it is necessary for my child to take medication on a field trip away from school, I will provide one school day's supply of the medication in the original prescription bottle for my child to self-carry and self -administer.

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Parent/Guardian Signature   Date   Home Phone Number

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To be completed by your child's physician

________________________________ is under my care. Please give the medication prescribed by me as follows:

Name of Medication____

Dosage in School____

Approximate Time of Administration____

Diagnosis____

Side Effects____

Other Instructions____

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Signature of Physician   Date   Phone number