Muskingum County
Board of Developmental Disabilities

Dream ★ Believe ★ Achieve

PHYSICIAN'S AUTHORIZATION / REQUEST FOR HEALTH CARE SERVICES

Student Name_____ Date of Birth_____

Address_____

Grade/Classroom_____Allergies_____

The Above Student is Under My Care and Should Receive:

Medication Name: _____ Dosage: _____

Route: _____ Time to be given: _____

If PRN please list parameters (symptoms) for use: _____

Special Instructions: _____

Side Effects to be reported: _____

Start Date_____ Stop Date_____

_____ _____

Physician's Signature Date Physician's Address

_____ _____

Physician's Printed Name Physician's Phone Number

I hereby request and give my permission to the Program Nurse or trained staff delegated by Program Nurse to administer the above medication(s) as ordered by physician. I agree to be responsible for supplying the medications in the original container and have pharmacy label from the pharmacy. I agree to notify the Program Nurse of any changes in medication(s).

_____ _____

Parent's Signature Date

_____

Parent's Printed Name

BL 4/21