



Autism
Academy
of
Learning

219 Page St.; Toledo, Ohio 43620 Phone: (419) 865 - 7487 Fax: (419) 865 - 8360

Authorization for Medication

Name of Student _____ Date of Birth _____
School _____ Date _____

Medication Treatment Plan to be completed by Physician

Diagnosis _____

Medication, Dosage, Specific Time and Directions for Administration _____

Note: Medication must be supplied in the original prescription container. Ask the pharmacist to provide the medication into two completely labeled containers, providing one for the home and one for school.

Side Effects/Special Instructions _____

Print Name or Stamp of Physician

Physician's Signature

Physician's Phone Number

Physician's Fax Number

Parental Permission

I grant permission for my child to receive prescribed medication at school. In the absence of the nurse, the Principal shall appoint a designee to give medication during the school day. All persons administering medication must have prior training by the school nurse.

Signature of Parent/Guardian

Date