Boulder Valley Waldorf School

Physicians Authorization to Administer Medications

Please return this form ONLY if your child requires medication to be dispensed at school.

Child's Name: _____ Age: _____

Childcare Facility: _____ Grade: _____

Teacher(s): _____

Primary Healthcare Provider: _____

Address: _____ Phone: _____

Medication: _____ Dosage: _____ Route: _____

Purpose of Medication: _____

Time of Day Medication is to be given: _____

Possible side effects: _____

Anticipated number of days it needs to be given at childcare facility: _____

_____ _____

Signature of person with prescriptive authority **Date**

PLEASE NOTE: The prescription medication is to be brought to the Boulder Valley office in its original pharmacy container and be within the noted expiration date appropriately labeled with child's first and last name by the pharmacy or person with prescriptive authority along with this medication authorization order.

I hereby give my permission for _____ to take the above prescribed or over- the-counter medication at the childcare facility as ordered. I understand that it is my responsibility to furnish this medication.

_____ _____

Signature of Parent/Guardian **Date**