

THE WOODHALL SCHOOL

ACADEMIC YEAR 2016 - 2017

PHYSICIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

THE SCHOOL MUST HAVE ON FILE A WRITTEN PRESCRIPTION FOR EACH MEDICATION OR FOR ANY CHANGE IN THE PRESCRIPTION. Please complete and send back to: <u>The Woodhall School</u>.

COMPLETE ONE FORM FOR EACH MEDICATION PRESCRIBED.

STUDENT NAME	BIRTHDATE / /
Address	
Condition for which drug is being administered	
Please select one: ☐ NEW Rx ☐ Dose change [□ D/C Medication starting on//
DRUG INFORMATION	
Rx Name	
Dose Method	of administration
Time of administration (circle one) 7AM 12:30PM 6PM	7AM meds are given at 10AM
Days of administration (circle all that apply) Mn Tu Wd	Th Fr Sa Su and 12:30PM med are given at 2PM.
Medication shall be administered from	to
•	
If there are any side effects, suggestions for management	
Is this a controlled drug? ☐ Yes ☐ No ☐ If yes, DEA number	
Examining physician (printed)	MD/ DDS
Address/City/State/ZIP	Phone
Signature	Date