THE WOODHALL SCHOOL

ACADEMIC YEAR 2017 – 2018

HEALTH

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: The Woodhall School PO BOX 550 BETHLEHEM CT 06751 FAX: 203.266.5896**

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 9PM

Days of administration (circle all that apply) Mn Tu Wd Th Fr Sa Su

Please note: On Sundays, 7AM meds are given at 10AM and 12:30PM med are given at 2PM.

Medication shall be administered from _____ to _____
MM/ DD/ YYYY MM/ DD/ YYYY

Relevant side effects to be observed, if any _____

_____

_____

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 _____