**YOUR PHYSICIAN MUST SIGN THIS FORM – PLEASE BRING THIS FORM WITH YOUR CHILD’S MEDICATION TO THE HEALTH CENTER ON REGISTRATION DAY**

**Physician Authorization For Administration Of Medication**

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**Student’s Name Birthday Date**

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**Medication/ Health Care Treatment Dosage Time to be administered**

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**Intended effect of this medication**

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**Expected side effects, if any**

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**Other medications student is taking**

**ISD is a residential school and medication refills can be obtained here. Student may self-administer medication under the supervision of the Health Center Nurse or school staff. Please attach a prescription with the number of refills and your DEA number.**

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**Prescriber’s signature Date signed**

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**Number of Refills DEA #**