THE AUTISM ACADEMY OF LEARNING

110 ARCO DRIVE TOLEDO, OHIO 43607 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, one for home use and one for school use.

Side Effects / Special Instructions _____

_____

_____ _____

Print Name or Stamp of Physician *Physician's Signature*

_____ _____

Physician's Office Phone Number *Physician's Office Fax Number*

Parental Permission

I grant permission for my student to receive prescribed medication at school. All persons administering medication must have prior training in medicine administration provided by a qualified nursing professional.

_____ _____

Signature of Parent/Guardian *Date*