FORM 314-A1

LIMESTONE DISTRICT SCHOOL BOARD
AUTHORIZATION AND REQUEST FOR ADMINISTRATION OF PRESCRIBED MEDICATION/MEDICAL PROCEDURES

Student Name: _____ School: _____ Grade: _____

Date of Birth: _____ Teacher: _____ Classroom # _____
(year/month/day)

Part One: Physician's Statement				
Drug (gen/trade name) Formulation (descrp.)				
Dose (eg. mg., volume) **Administration** (eg. oral, inhaled)				
Dosing Interval				
Indication				
Length of Treatment				
Previous Use? (Y/N)				
Anticipated Untoward Reaction? (list below)				
Special Instruction? (Y/N) (list below)				
Anticipated Untoward Reaction Drug: Reaction: Action to Be Taken: Drug: Reaction: Action to Be Taken:				
Special Instructions: <u>Requirements/Warnings</u> (storage, availability, etc.) Drug: Drug:				

Physician's Signature: _____ Address: _____ Date: _____
Physician's Name: _____ Phone: _____ (yr/mo/day)