PIERREPONT SCHOOL
One Sylvan Road North ● Westport, CT 06880

MEDICATION AUTHORIZATION
To be completed by parent or guardian
Please print all information

Student name: _____

Date of birth: _____

Physician Name: _____ ph: _____

I hereby authorize my child, listed above, to receive the following medication as needed:

_____Tylenol Dose to be given: _____Reason for medication: _____

_____Advil Dose to be given: _____Reason for medication: _____

_____Benadryl Dose to be given: _____Reason for medication: _____

_____Other (*Fill out information below*)

Name of medication: _____

Dose to be given: _____

Time to be given: _____

Duration of treatment (indicate dates): From _____To_____

Possible side effects and adverse reactions (if any): _____

Comments: _____

_____

Name of medication: _____

Dose to be given: _____

Time to be given: _____

Duration of treatment (indicate dates): From _____To_____

Possible side effects and adverse reactions (if any): _____

Comments: _____

_____

_____ _____

Signature of parent or guardian **Date**