MODEL SECONDARY SCHOOL FOR THE DEAF
MEDICATION ADMINISTRATION AUTHORIZATION

SHS – 3

Student's Printed Name _____ Date of Birth _____

If your child is **NOT** taking any prescribed or over the counter medication, please check (✓) here ☐ and sign your name and date here.

_____.

Return this form with MSSD Student's Medical History From.

MSSD PARENTS/GUARDIANS: If your child is taking any prescribed medications, over-the-counter medicines, vitamins, or supplements**,** take this form to your child's physician to complete. Return this completed form with the MSSD Student's Medical History Form.

Diagnosis: _____

_____

NAME OF MEDICINE	DOSAGE/FREQUENCY	SIDE EFFECTS

Is patient authorized to take medicine himself/herself? ❑ Yes ❑ No

Dates medicine should be administered are from: _____ to _____

Comments: _____

_____

Physician's Name _____ ( ) Phone Number _____

Street _____ ( ) Fax Number _____

City/State/Zip _____

Physician's Signature _____ Date _____