Carle Auditory Oral School

Carle

CARLE AUDITORY ORAL SCHOOL/ CARLE FOUNDATION HOSPITAL
PHYSICIAN AUTHORIZATION AND PERMISSION FOR MEDICATION ADMINISTRATION

Student's Name: _____ _____ Today's Date:_____
(Last) (First) Birthdate

Student attends the following days/times:_____

- Medication is administered following these guidelines:
  - Physician/Prescriber signed, dated authorization to administer the medication
  - Parent signed, dated authorization to administer the medication
  - Medication is in the original labeled contained as dispensed (or the manufacturer's labeled container
  - Medication label contains the student name, name of the medication, directions for use and date

Physician Authorization:

_____ _____ _____
Medication Dosage Time to be administered

_____ _____
Intended effect of this medication Expected side effects, if any

_____ _____
Administration instructions Other medications student is taking

_____
Discontinue/Re-Evaluate/Follow-up Date (circle one)

_____ _____
Physician Signature Date Signed

_____
Physician's Emergency Phone #

If special instructions, please describe how medication is to be administered below:

_____
_____
_____

Carle Foundation Hospital
Carle Auditory Oral School
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Urbana IL 61801
217/326-2824