MERCAZ ACADEMY
ישיבת מרכז

Authorization for Medication in School

Must be signed by BOTH parent and healthcare provider

A. To be completed by the Parent or Guardian:

I request that my child _____ Date of Birth:_____
receive the medication as prescribed below by our health care provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy*.

Signature (Parent or Guardian):_____

Telephone: Home: _____Work: _____Cell: _____

Date: _____

B. To be completed by the Private Healthcare Provider:

I request that my patient, as listed below, receive the following medication:

Name: _____ DOB _____

Diagnosis: _____

Medication	Dosage	Frequency/Time to be Taken	Route of Administration

Possible Side Effects and Adverse Reactions (if any): _____

Healthcare provider's Signature: _____ Date: _____

Address: _____ Phone: _____

*Medication must be in original pharmacy labeled container with specific orders and name of medication.
*Medication and refills must be brought to school by parent, guardian, or responsible adult.

This medication order is valid for the current school year.