North Wall Schools

Medical Treatment Authorization Form

Child's N	Name					
Reason fo	or Medicati	ion				
Name of Medication				Amount		
Frequency			Times	_ Times Given at Home		
Method o	f Administ	tration at North Wall Schoo	ols			
Amount						
child.					and/or treatment to my Date	
	(Parent)					
Record of		ons Given (to be filled out b				
Date	Time	Staff Signature	Date	Time	Staff Signature	
		North W	Vall Scho	ale		
		Medical Treatmen	ı Aumori	zauon Fori	<u>m</u>	
	т					
Child's N	Name					
Reason fo	or Medicati	ion				
Name of Medication						
Frequency Times Given at Home						
Method of Administration at North Wall Schools Times to be Given						
Amount Times to be Given						
I authori	ze North V	Wall Schools to give the al	bove med	lication(s)	and/or treatment to my	
child.						
					Date	
Signature	· 	(Parent)			Date	
	(raiciii)					
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Record of	f Medicatio	ons Given (to be filled out b	by the per	son who gi	ives the medication):	
Date	Time	Staff Signature	Date	Time	Staff Signature	
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