North Wall Schools

Medical Treatment Authorization Form

Child's Name _____

Reason for Medication _____

Name of Medication _____ Amount _____

Frequency _____ Times Given at Home _____

Method of Administration at North Wall Schools _____

Amount _____ Times to be Given _____

Start and Stop Date_____ Expected Side effects:_____

I authorize North Wall Schools to give the above medication(s) and/or treatment to my child.

Signature _____ Date _____

(Parent)

Record of Medications Given (to be filled out by the person who gives the medication):

Date	Time	Amount Given	Staff Signature	Date	Time	Amount Given	Staff Signature
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
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____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____
____	____	_____	_____	____	_____	_____	_____