PEDIATRIC AFFILIATES, P.A.

SPECIALIZING IN INFANTS, CHILDREN AND ADOLESCENT MEDICINE

ROBERT A. SHANIK, M.D., F.A.A.P. **IRA HAIMOWITZ, D.O.F.A.A.P.**

Permission to Medicate

Schools require an authorization form signed by the physician and the parent/guardian of any student that must receive medication during the school day and/or school activities.

Date:

Student Name:

Student DOB:

School:

Nurse:

Name of medication:

Dosage of medication:

Time dosage is to be taken:

Length of time medication is required:

Parent signature_____ Date_____

Physician signature_____ Date_____

This form must be returned to the school nurse!!!!!!!

Office Stamp

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