SENATOBIA MUNICIPAL SCHOOL DISTRICT
104 McKie Street
Senatobia, MS 38668
Jay Foster
Superintendent of Education

Medication Authorization Form

School Year:_____

Child's Name:_____DOB_____

PHYSICIAN'S ORDER SECTION:

Name of Medication:_____

Dosage:_____Time(s) to be given:_____

Reason for Medication:_____

Termination date at end of current school year.

List ONLY side effects that must be reported to parent or MD:_____

_____

☐ Child may self-administer medication

☐ Child may self-administer medication with supervision

☐ Child may NOT self-administer medication

Physician's Signature:_____Date:_____

Address:_____Phone:_____

Parents complete this section.

I agree with the above Physician Order and request this medication be given to my child as ordered above.

Parent Signature:_____Date:_____