THE LOWELL SCHOOL
AUTHORIZATION FOR MEDICATION
(EMERGENCY PLAN)

STUDENT'S NAME: _____ DATE OF BIRTH: _____

_____ MY CHILD DOES NOT TAKE MEDICATION.

_____ MY CHILD DOES TAKE MEDICATION.

NAME OF MEDICATION DOSAGE TIME OF DAY

_____

_____

_____

_____

DOCTOR'S NAME: _____

DOCTOR' S ADDRESS: _____

DOCTOR'S PHONE NUMBER: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

IF YOUR CHILD TAKES MORE THAN ONE MEDICATION, PLEASE PUT IN SEPARATE ENVELOPES.

PLEASE WRITE YOUR CHILD'S NAME ON EACH ENVELOPE WITH THE OF THE MEDICATION.

ADDITIONAL COMMENTS:

_____

_____