

Long Term Medication Authorization

I certify that in my opinion, it is medically necessary that the medication described below be administered to _____ during school hours and that this medication may be administered by a member of the staff designated by the Head of School.

Prescription: Medication _____
Dosage _____
Time _____
Duration _____
Date of Prescription _____
Special Instructions _____

Signature of Physician

Date

St. Michael's Episcopal School
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