



PARENT/GUARDIAN, please complete the following:

\_\_\_\_\_

(Name of Student-Please print)

\_\_\_\_\_

(Program)

I hereby request that an authorized representative of AYS administer the **prescription** medication listed below to my son/daughter. I understand that I may withdraw this consent at any time by submitting a written request to AYS personnel. Furthermore, I understand this consent is valid for only one school year.

\_\_\_\_\_

(Parent/Guardian Signature)

\_\_\_\_\_

(Date)

PHYSICIAN, please complete the following:

\_\_\_\_\_ is a patient under my care. The following **prescription** medication would need to be administered during the AYS program. The following is a description of the medical order:

Name of the **prescription** medication: \_\_\_\_\_

Dosage & directions for administration: \_\_\_\_\_

Purpose: \_\_\_\_\_

Possible side effects to be reported: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Physician Signature)

\_\_\_\_\_

(Physician Printed Name)

\_\_\_\_\_

(Date)

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