District Five Schools of Spartanburg County

Physician Authorization for Medication Administration

<table>
<tr><td colspan="3">Physician:</td></tr>
<tr><td colspan="2">Student's Name:</td><td>Date of Birth:</td></tr>
<tr><td>School:</td><td>Grade:</td><td>Teacher:</td></tr>
<tr><td colspan="3">Diagnosis:</td></tr>
<tr><td colspan="2">Name of Medication:</td><td>Dosage:</td></tr>
<tr><td colspan="2">Time of Administration:</td><td>Duration:</td></tr>
<tr><td colspan="3">Special Instruction for Medication/Nursing Procedure:</td></tr>
<tr><td colspan="2">Physician's Signature:</td><td>Date:</td></tr>
<tr><td colspan="2">Physician's Name (PRINT)</td><td>Phone:</td></tr>
<tr><td colspan="2">Address:</td><td></td></tr>
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