COMPREHENSIVE PSYCHIATRIC ASSOCIATES, LLC

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The following section is to be completed by **PARENT:**

School_____

School Phone:_____ Fax:_____

Child's Name_____ M F _____
Last **First** **Sex** **Date of Birth**

I give permission for the exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime.

I request that my child be assisted in taking the medication(s) described below at the school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below)

_____ _____
Parent/Guardian Signature **Date**

To Whom It May Concern:

Current diagnosis: _____

Current medication: _____

Form:_____ Dose:_____

Time to be administered:_____

If medication is to be given WHEN NEEDED, describe indications:_____

_____

Is child authorized to medicate herself/himself: **YES** **NO**

Other: _____

_____

_____
Provider's Signature

_____
Date