AUTHORIZATION FOR DISPENSING MEDICATION
IN SCHOOL OR CAMP

PARENT/GUARDIAN:

I request that my child _____ receive in school/camp administration of Tylenol as directed below and prescribed by

_____
Physician's Name

_____
Signature of Parent/Guardian

Telephone No. _____ Date _____

PHYSICIAN:

I request that my patient _____receive the following medication:

Name of Medication: Tylenol
Diagnosis: As needed for fever or pain
Prescribed Dosage: _____ mg every 4 to 6 hrs. as needed
Time to be taken during school or camp hours: As needed
Expected duration of treatment: As needed, through the school year or camp session
Possible side effects and adverse reactions:
Other recommendations: Inform parent of fever, if child looks ill, have seen by health care provider

Print Name:_____ **Tel. No:** 617-323-4440

Signature: _____ **Date:** _____