Physician Authorization Form
Prescription Medication to be given at San Antonio Christian School

Student's Name_____Age_____ Date of birth_____

Grade_____Teacher (if Elementary) _____

Prescription Medication _____

Dose _____

Time to be given _____

Dates to be given _____

Reason for medication _____

Special Instruction s_____

Precautions/Untoward Restrictions/Interventions/Emergency Measures_____

_____

Activity Restrictions _____

_____

_____ _____
Physician's Signature Parent's Signature

_____ _____
Physician's Name (Printed) Parent's Name (Printed)

_____ _____ _____ _____
Physician's Phone Number Date Parent's Phone Number Date

SuEllen Hotchkiss, RN
Elementary School Nurse
210-248-1625 x146
Fax: 210-342-0146