Physician Authorization for Medication to be Taken During School Hours when packaging is not dosed for child's age.

Date:
To:
Tel:
Fax:

From: Angela Jones, Michele Cadaret or Miranda Miller Directors, Paradigm Care & Enrichment Center per Parent Request

☐Waterford Tel: 248-363-9800 ☐Waterford Fax: 248-363-0992
☐Canton Tel: 734-354-9600 ☐Canton Fax: 734-354-0083

Child's Name: _____ Date of Birth:____/___/_____ Current Age:_____/____ yrs/mos.

Medication sent to school by the Parent:

The following is to be filled out by the Physician:

Diagnosis for which medication is being given.	
In attempt to prevent the spread of disease to our student's and staff the child must not attend our program if contagious. Is the child currently contagious?	☐Yes ☐No, may return to school/care.
Dosing amount for the above named medication to be administered to the child.	
If medication is to be given daily at what time? Note: Paradigm only administers medication at 1PM and 3PM.	☐1:00PM ☐3:00PM
If medication is to be given "As Needed" please explain.	
Number of days Paradigm should continue to administer this medication. (State Licensing requires a new permission form after 30 days.)	Date to end:___/___/___(30 days max)
List Possible Side Effects or other information that we should be aware of.	

Physician's Signature _____Date ____/_____/_____

Physician's office stamp
(Required for authenticity)