Islamic School of San Diego

Physician's Authorization to Administer Medications

Student's Name: _____ Birthdate: _____

Medication: _____ Dosage: _____

Period of Administration, Beginning date: _____ Ending Date: _____

Times of Administration: _____

Method of Administration: _____

I am a physician licensed by the State of California and I authorize Islamic School of San Diego to assist the student named above in taking the required medication as directed above.

Doctor's Signature Doctor's Name Phone Number

Parent's Authorization to Administer Medications

I authorize Islamic School of San Diego to assist the student named above in taking the required medication as directed by the doctor. I recognize that this is a service that the school is not legally required to perform. I agree to save and hold the school, its employees, agents, and officers, harmless from all liability, law suits or claims which might arise as a result of administering the medication in accord with this request.

Parent's Signature Parent's Name Phone Number

Date	Time of Administration	Assisted by:

7050 Eckstrom Avenue, San Diego, CA 92111 Phone: (858) 278-7970 FAX: (858) 278-7995