



Infants • Children • Adolescents

Associated Pediatricians, LLC

THOMAS E. LUDWIG, M.D.
JEFFREY E. MILLER, M.D.
SUSAN L. BISHOP, M.D.
DIANNA W. BROGAN, M.D.
PABLO A. BUKATA, M.D.
ALICE C. HARRINGTON, M.D.
ELIZABETH K. CAMPBELL, M.D.

Authorization to Administer Medication

Name _____ School _____

I have prescribed the medication(s) indicated below and authorize a designee of the school to administer the medication(s) at school as follows

1. Medication _____ Dosage _____ Time _____
Reason for giving _____

2. Medication _____ Dosage _____ Time _____
Reason for giving _____

Date _____ Physician's signature _____

Parent's Authorization

I authorize the designee of the school to administer medication(s) as prescribed above. I understand that I will be responsible for furnishing no more than one week's supply of medication to the school at any time.

Date _____ Parent or Guardian _____
Phone _____ Address _____

VALPARAISO OFFICE

Glendale Medical Center
1101 E. Glendale Boulevard
Suite 101
Valparaiso, IN 46383
Phone: 219/462-0555
Fax: 219/548-3681

PORTAGE OFFICE

Portage Community Hospital
3630 Willowcreek Rd.
Suite 6
Portage, IN 46368
Phone: 219/364-3250
Fax: 219/364-3251