

PUTNAM COUNTY SCHOOLS
PARENT CONSENT/PHYSICIAN'S ORDERS
PHONE # (931) 526-9777
FAX # (931) 520-1442

TO BE COMPLETED BY PARENT OR GUARDIAN *** PLEASE PRINT

Child's social security number _____ Child's date of birth _____

Child's name _____

Last

First

Middle

Address _____

Home phone # _____ Business phone # _____

School _____ Grade _____ Teacher _____

Parent's/Guardian's name (Please Print) _____

ALL CURRENT MEDICATIONS

My child has the following other chronic illnesses/disabilities: _____

Allergies: _____

Child's Limitations or Special Considerations: _____

I understand that it is my responsibility to keep this information current. Please notify School personnel and provide an updated/current form on at least an annual basis. My signature indicates my permission for administration of medication by designated personnel at my child's school.

Parent's/Guardian's Signature: _____

TO BE COMPLETED BY PHYSICIAN *** PLEASE PRINT

Diagnosis: _____

Treatment: _____

Limitations: _____

Special Instructions: (1) _____

(2) _____

(3) _____

Physician's Signature _____

Date signed _____

Physician's Name (Please type) _____ Phone# _____

Office Address (Please type) _____