Medication Prescriber/Parent Authorization Form

Student Name:_____ Birthdate: _____ Teacher: _____ Grade:_____ School Year: _____

To be completed by physician/licensed prescriber:

	Medication Name	Dose	Time to be given	Form/Route*	Side Effects	Adverse Reactions
1						
2						

*Routes ~ oral (pill/capsule/chewable, liquid) ~ inhaled (inhaler, nebulizer) ~ topical skin application ~ topical (eye drop, ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if p.r.n.): _____

If p.r.n., list symptoms/conditions under which medication is to be given: _____

Reason for medication (optional): Medication #1_____ Medication #2 _____

Special Instructions: _____

Start date if not beginning of the school year: _____ Stop date if not end of the school year: _____

_____ _____ _____

Physician's signature Date Physician's Printed name

Physician's Phone #: _____ Fax #: _____ Address: _____

To be completed by parent/guardian:

I request and give permission for (name of child) _____ to receive the above medication(s)/treatment at school according to standard school district policy and for the physician('s)/staff and school district staff to share information needed to assist my child with medication needs. (Schools require parent/guardian to bring medication in its original container).

_____ _____

Parent/guardian signature Date

(*p.r.n. - definition is as needed)