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 (list0

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

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

Special Instructions: _____

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