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