MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM

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

Address:_____City: _____ Zip:_____

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 (eye drops, ointment) ~ topical ear drop ~ injection ~ other (list)

List minimal frequency between doses (especially if P.R.N.): _____

If P.R.N., list symptoms/condition under which medication is to be given: _____

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

Special instructions: _____

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

Physician's Signature: _____ Date: _____Physicians Printed Name:_____

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

To be completed by parent/guardian:
I request and give permission for above named 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 Signature: _____ Date: _____ Phone Number: _____