MEDICATION PRESCRIBER/PARENT AUTHORIZATION FORM

Student Name: ____________________ Birthdate: ________ Teacher/Counselor: _____________ School: **TONDA** 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: ______________________________