

Medication Prescriber/Parent Authorization Form

For Prescription Drugs and Over-the Counter Medication

Student Name: _____ Birthday: _____ 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 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 to assist my child with medication needs.

(Schools require parent/guardian to bring medication in its original container)

Parent/guardian signature

Date