PARENT AND PRESCRIBER'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL

Authorization for Administration of Medication

A. To be completed by the Parent or Guardian:

I request that my child, ____, grade ____________
Receive the medication as prescribed below by our licensed health care prescriber. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I understand that the school nurse or other designated person, in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): ____

Telephone #: ______________________________ Date: ______________________________

B. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student: ______________________________ Date of Birth: ______________________________

Diagnosis: ____

Name of Medication: ____

Prescribed Dosage and Means of Administering: ____

____

Time to be Taken During School Hours/Field Trip: ____

Expected Duration of Treatment: ____

Possible Side Effects and Adverse Reactions (if any): ____

Other Recommendations (including PRN or carry/self-administration orders): ______________________________

____

Name and Title of Licensed Prescriber (print): ____

Doctor's Signature: ______________________________ Doctor's Stamp: ______________________________