

Medication Prescriber/Parent Authorization Form

Student's Name: _____ Birthdate: _____ 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, ear drop), Injection, Other

List minimal frequency between doses (especially if p.r.n.): _____

If p.r.n., list symptoms/conditions under which medication may be given: _____

Reason for medication: _____

Special instructions: _____

Start date if not beginning of school year: _____ Stop date if not end of 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 my child _____ to receive the above medication(s)/treatment according to school district policy, and for the physician's staff and school district staff to share information regarding my child's medication needs.

Parent/Guardian Signature

Date

