PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

A. To be completed by the parent or guardian:

I request that my child _____DOB _____ receive the medication as prescribed below by our Health Care Provider. The medication is to be furnished by me in the properly labeled original container from the pharmacy or OTC container*.

PLEASE CHECK ONE:

☐ I understand that the school nurse will administer medications to my child, or in the case of the absence of the school nurse, other designated person will assist my **self-directed child** to take his or her own medication (including field trips).

☐ I understand that administration of any medications to my **non self-directed child** must remain the responsibility of the school nurse, licensed practical nurse under the direction of a school nurse, physician, or parent.

Signature (Parent or Guardian): _____

Telephone: Home_____ Cell_____ Work _____ Date_____

B. To be completed by physician:

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

Name of Student _____ DOB _____

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY/TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment:

Possible Side Effects and Adverse Reactions (if any):

Physician's Signature _____ Date:_____

Address: _____ Phone:_____

* Medication must be in original pharmacy labeled container with specific orders and name of medication.
* Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with parent(s)/guardian(s):

Parent Signature:_____Date:_____