American Overseas School of Rome

PRESCRIPTION MEDICATION AUTHORIZATION FORM

Student's Name_____ **DOB**_____ **Gender**____ **Grade**_____

THIS PORTION TO BE COMPLETED BY THE PHYSICIAN/HEALTH CARE PROVIDER

Name of Medication	Dosage	Method of Administration	Time of Day to Be Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If given "prn" specify the length of time between doses:_____
Diagnosis and reason for medication to be given during school hours:_____
Anticipated action:_____
Possible side effects of medication:_____
Emergency Procedure in case of serious side effects:_____
Student may carry and/or self-administer this medication during school hours: ☐ Yes ☐ No

A backup supply of the same medication must be provided by the parents and stored with other medications at school.

I request and authorize the school to administer the above medication in accordance with the instructions indicated above from _____to_____not to exceed current school year.

Health Care Provider's Signature:_____ **Date:**_____

Name: _____ **Address:**_____
(Print or Type)

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student. I request and authorize the School Nurse to administer this medication, during school hours only in accordance with the health care provider instructions indicated above.
I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

MEDICATION WILL BE SUPPLIED TO THE SCHOOL IN THE PROPERLY LABELED ORIGINAL CONTAINER.

Last Name:_____ **First Name:**_____ **DOB:**_____

Parent/Guardian's Signature: _____ **Date**:_____