AUTHORIZATION FOR MEDICATION

The following section is to be completed by the **PARENT:**

School ____

Child's Name ______________________________ DOB ____________ Gender _________

Physician's Name ___________________________________ Phone # ___________________

Physician's Address ____

I request that my child be assisted in taking the medication(s) described below at school by authorized persons as authorized by my health care practitioner and me (see below). I understand that I must transport medication to and from the school.

Parent/Guardian Signature _____________________________________ Date _____________

Home Phone # ________________________ Emergency Phone # _______________________

The following section is to be completed by the **HEALTH CARE PRACTITIONER:**
(Note: School personnel should not administer any medication that could be taken at home.)

Diagnosis for which medication is given ____

Name of medication(s) ____

Form __________________________________ Dose ____________________________________

If it is medically necessary to administer at school, at what time____________________________

If medication(s) is to be given "when needed", describe indications ________________________
____

How soon can it be repeated ____

List significant side effects ____

Length of time this treatment is recommended ____

Is this a rescue medication? ____

Is the student authorized to self-carry and administer the medication? _______________________

OTHER INFORMATION

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Signature of Health Care Practitioner______________________________ Date_____________

Updated 3/8/13