Solebury School Medication Authorization Form

To be signed by both prescriber and parent/guardian

Name of Student: ____________________________ Today's Date:_______________
Student's date of birth: _____________________________

Name of Medication:____
Indication for Medication:____
____
Dose: ______________________________ Route: __________________________
Time/Frequency: ____
Date to Start or Date Started:___________________Date to stop:_______________
Known side effects:____
Additional Instructions/Comments: ____
____

Name of Medication:____
Indication for Medication:____
____
Dose: ______________________________ Route: __________________________
Time/Frequency: ____
Date to Start or Date Started:___________________Date to stop:_______________
Known side effects:____
Additional Instructions/Comments: ____
____

Name of Medication:____
Indication for Medication:____
____
Dose: ______________________________ Route: __________________________
Time/Frequency: ____
Date to Start or Date Started:___________________Date to stop:_______________
Known side effects:____
Additional Instructions/Comments: ____
____

Prescriber's Signature:____
Prescriber's Printed Name:____
Prescriber's Address and Telephone:______________________________________
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____
____

I authorize Solebury School personnel to administer the medication(s) named above to my child in the manner as stated. I release any liability in relation to the administration of this medication. If any changes to the above medication(s) are made by the prescribing health care provider, I will obtain a new copy of this authorization form. I authorize Solebury School to contact the prescribing health care provider to clarify medication orders as needed.

Parent/guardian printed name: ____
Date Signed: ____
Parent/guardian signature: ____