MEDICATION AUTHORIZATION FORM

Student's Name (please print) | Date of Birth | Grade | Date

Medications may be administered in school in accordance with the School Medications Procedures. No medications (including over the counter) may be administered in school unless both the student's physician and parent/guardian have completed , signed, and returned the following to the School Principal or her designee:

Physician's Order

Medication/Health Care Treatment | Dosage | Time(s) to be administered

Intended effect of this medication | Expected side effects, if any

Other medications the student is taking

Administration Instructions

Physician's Signature | Date Signed

Physician's Name (Please print) | Telephone Number

Physician's Address | City, State, Zip Code

Parent Signature | Date | Emergency Phone Number

School Representative's Signature | Date Received

PLEASE NOTE: THIS FORM MUST BE RENEWED EVERY SCHOOL YEAR