

MEDICATION/TREATMENT AUTHORIZATION FORM

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School Name \_\_\_\_\_

The following section is to be completed by the parent or legal guardian:

I hereby grant permission to the principal or his/her designee of \_\_\_\_\_ School to assist in the self-administration of the prescribed or over-the-counter medication and/or treatment to my child while in school and away from school while participating in official school activities. It is my responsibility to notify the school if and when these orders change.

Parent/Guardian name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Business Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Over the Counter Medication Authorized: \_\_\_\_\_

Instructions to Assist with the Self-Administration by the Student of the Medication: \_\_\_\_\_

List child's allergies: \_\_\_\_\_

The following section is to be completed by the prescribing physician for prescription medication:

*(A separate form must be completed for each medication or treatment prescribed)*

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following medication/treatment, which is necessary to be given in school. I am aware that trained non-medical staff may administer this physician prescribed service.

This order is to be effective for the school year: 201\_\_\_\_ - 201\_\_\_\_ or earlier stop date: \_\_\_\_\_

Diagnosis *(for this medication/ treatment)*: \_\_\_\_\_

Treatment: \_\_\_\_\_

Name of Medication: Brand: \_\_\_\_\_ Generic: \_\_\_\_\_ Strength*(i.e. mg/tab)*: \_\_\_\_\_