



Authorization for Discontinuation of Medication at School

Name of Student: _____ Birthdate: _____

School: _____ School Year: _____ Grade: _____

Medical Condition / ICD 10 CM	Medication	Strength mg/ml	Dose # Tablets	Time(s) Frequency	Route	Stop Date

Print or Type Name of Physician / Licensed Prescriber

Signature of Physician / Licensed Prescriber

Clinic Address

Fax Number

Phone Number

Date

Parent / Guardian Authorization

- I request that the above medication(s) no longer be given during school hours as ordered by this student’s physician/licensed prescriber
- I give permission for the Licensed School Nurse (LSN) or designee to communicate with the student’s teachers about the student’s health condition(s) and the discontinuation of the medication(s).
- I give permission for the LSN or designee to consult (in oral or written format) with the above named student’s physician/licensed prescriber regarding any questions that arise with regard to the discontinuation of the listed medication(s) or medical condition(s) that was being treated by the medication(s), as well as ongoing data on the discontinuation of the medication effects provided to physician/licensed prescriber and parent/guardian via monitoring form.**

This authorization may be revoked by you at any time in writing and automatically expires one year from signature

NOTE: Medication is to be transported to and from the school by a parent/legal guardian.

Due to privacy issues, health information is not shared with programs that take place outside of the educational day.

Parent/Legal Guardian Signature

Relationship to Student

Cell Phone

Day Phone

Date