WATERLOO CENTRAL SCHOOL DISTRICT

Medication Authorization Form

School: _____

School Year: _____ Grade: _____

Physician's Order

Name of Child: _____ DOB _____

Name of Medication: _____

Dosage: _____

Time/Frequency: _____

Reason for Medication: _____

Possible Side Effects: _____

Estimated Termination Date: _____

(All authorization expire at the end of the school year)

- ☐ Child is knowledgeable about this medication and how to administer it
- ☐ Child may self-administer medication
- ☐ Child may self-carry medication (Inhaler ONLY)

Date _____ Physician's

Signature _____

Address _____

_____

Phone Number _____

Parental Permission

I request this medication be given to my child _____ as prescribed by my child's physician.

☐ My child may self-administer his/her medication ☐ May self-carry inhaler

Date _____ Signature _____

Parent/Guardian

Phone: _____

Work: _____