PHYSICIAN AUTHORIZATION FORM

To the Physician: The Board of School Trustees urges you to schedule, to the extent possible, medication or treatment of a student outside of school hours. When that is not possible, medications and/or treatment will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

Student Name: ____

Date of Birth: ____________________ **Grade:** _____________

Authorization is hereby given for the student (named above) to receive the medication marked below as indicated: (check all that apply)

_____________ Asthma Inhaler

_____________ Epi-Pen

_____________ Diabetic Supplies

___________ Self-Carry the Medication

___________ Self-Administer the prescribed medication as permitted by law

___________ Receive the prescribed medication indicated from designated school personnel

Medication name: ___________________________________ Dosage: _________________________

Medication is to be taken at the following times: ____

Beginning Date: ____________________________________ Expiration Date: ____________________

Procedure to follow in the event that medication does not produce the expected relief from student's

asthma attack/allergic reaction/glucose reaction: ____

____

Instructions or precautions (including possible side effects): _____________________________________

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Physician: I have prescribed the following medication (listed above) to be administered to student (listed above). The medication is to be taken at the following times (listed above).

__**Physician name, physician signature, and phone number are required to validate form.**__

Physician Name: ____ Phone: _______________________

Physician Signature: _____________________________________ Date: ________________________

Parent/Guardian Name: __________________________________ Phone: _______________________

Parent/Guardian Signature: _______________________________ Date: _________________________