

AUTHORIZATION FOR PRESCRIPTION MEDICATION OR TREATMENT

Part A: To be completed by the physician

Name of Student: _____ DOB: _____

Street _____ PO Box _____

City _____ State _____ Zip _____

School: _____

I have prescribed the following:

Medication/Treatment _____

Dosage _____

Time to be given at school _____

If **Asthma inhaler** may student carry on person: _____

If **Epi-pen** may student carry on person: _____

Is student trained to self administer medication? _____ Yes _____ No

Begin Date: _____ End Date: _____

Side effects, Instructions, or precautions:

Physician's Signature

Date

Printed/Typed Name

Telephone

Fax

Part B: To be completed by the Parent /Guardian

I request authorized school personnel to follow the medical instructions requested in PART A. I agree to see that the medication is delivered to the school: to notify the school if there is a change in physicians: to notify the school if the medication, dosage, or procedure is changed or discontinued. I give my consent to the physician, school nurse, or their designees to send and/or receive information related to my child's health as they deem appropriate for the duration of this order as noted above.

*****Please note medication must be in pharmacy labeled bottle.**

DATE _____ Signature of parent/Guardian _____

****Note: Please pick up all medications at the end of the school year. They will be destroyed if they are not picked up