Petal School District

Medication Authorization Form

Student Name:_____ Date of Birth:_____

School:_____ Phone:_____ Fax:_____

******Prescription medication must be in the container in which it was purchased with a pharmacy label attached; over-the-counter medications must be in a new unopened bottle. No medication (including over-the-counter medication and supplements) will be given at school without a current prescription from a licensed physician.******

PARENT/GUARDIAN SECTION

I request that my child,_____, be assisted in taking the below prescribed medication at school by the nurse or principal's designee. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in health care provider. I authorize exchange of information between my child's Physician, District Nurse, or site administrator with regard to this medication request.

_____ _____ _____

Parent/Guardian Signature Date Phone Number

PHYSICIAN SECTION: *(to be completed by health care provider)* ***One Medication per Form***

Name of medication:_____

Dosage:_____

Time(s) to be given at school:_____

Route to be given:_____ Controlled substance? Yes

No

Reason for medication/Diagnosis:_____

Possible side effects & Emergency Response: _____

It is necessary for this medication to be taken during the school day at the time(s) indicated above.

Physician Signature:_____ Date:_____

Physician Name:_____

Clinic Address:_____

Clinic Phone Number:_____ Fax:_____

******Form must be renewed every school year or whenever the prescription changes.******