PATTONVILLE SCHOOL DISTRICT

2021-2022

PARENT AUTHORIZATION FORM
Prescription or Over the Counter Medications

Name of Student _____ Date of Birth _____Grade____
Last First M.I.

Name of Parent/Guardian _____ Ph#_____

I give my consent for this medication to be administered to the above student by the school nurse or other authorized person as prescribed by the physician or per manufacturer label on over the counter medication. **The School Nurse May Contact Your Physician As Needed.**

_____ _____
Parent/Guardian Signature Date

All medication will be provided by the parent

Medication	Reason for Giving	Form of medication - Tablet/capsule, Liquid, Inhaler, Nebulizer, EPI-Pen, Other	Special Directions Dose, Time etc.
Acetaminophen			
Ibuprofen			
Tums			

Can the medication stay at school: Yes ____ No____

Student's weight: for medication purposes _____

Physician's name _____

Physician's Phone # _____

Food/Drug Allergies - Yes ____ No ____

If yes, please list _____

_____

What are the symptom**s** _____

_____

I understand I may cancel this request at any time, and/or retrieve the medication from the school at any time. I give my permission to the school nurse to destroy any medication remaining at the end of the school year, if I do not pick it up.

***If dosage is changed, a new prescription label and/or prescriber's order will be needed.**