PARENT AND PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN SCHOOL AND SCHOOL ACTIVITIES

Student's Name:_____ DOB _____/ _____/ _____

A. To Be Completed by Parent or Guardian

I request that my child receive the medication as prescribed below by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. *I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication, including field trips.

_____ _____/ _____/ _____
Parent/Guardian Signature Date

Home Phone: (_____) _____ Work: (_____) _____ Cell: (_____) _____

B. To Be Completed by Physician

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ DOB _____ /_____ /_____
(First, Middle, Last)

Diagnosis: _____

MEDICATION	DOSAGE	FREQUENCY / TIME TO BE TAKEN	ROUTE OF ADMINISTRATION

Duration of Treatment: _____

Possible Side Effects and Adverse Reactions (if any): _____

_____ _____/ _____/ _____
Signature of Physician Date

Physician's Mailing Address: _____
Street Address

_____ (_____) _____
City / St / Zip Office Phone

*Medication must be in original pharmacy labeled container with specific orders and name of medication.
*Medication and refills must be brought to school by parent, guardian or responsible adult.

Plan reviewed with Parent(s)/Guardian(s):

_____ _____/ _____/ _____
Parent/Guardian Signature Date

I, _____ ❑ Do ❑ Do Not authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting TNCS. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

_____ _____/ _____/ _____
Parent/Guardian Signature Date